SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Prescription Drug	SERFF Tr Num: AEGX-126418328	State: Arkansas
TOI: H17G Group Health - Prescription Drug	SERFF Status: Closed-Approved-Closed	State Tr Num: 44327
Sub-TOI: H17G.000 Health - Prescription Drug	Co Tr Num: GH AR0052015F01	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 12/17/2009
	Date Submitted: 12/14/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: Prescription Drug
Project Number: GH AR0052015F01
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 12/17/2009

Deemer Date:
Submitted By: SPI ADMSLH
Filing Description:
NAIC #468-65021
Forms Filing

RE: SLRX2010GP - Prescription Drug Program

Forms including in Filing:
Group Prescription Drug Program
SLRX2010GP - Group Policy
SLRX2010GC - Certificate

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Employer
Explanation for Other Group Market Type:
State Status Changed: 12/17/2009
Created By: SPI ADMSLH
Corresponding Filing Tracking Number:

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

SLRX2010GA - Group Application
SLRX2010GE - Enrollment Form

The enclosed forms are being submitted for your review and approval. These forms are new and in compliance with the insurance laws and rules of your sate.

Group Policy Form SLRX2010GP provides coverage for prescription drug expenses. The product will be issued to employer groups.

These forms are being filed concurrently in our domicile state of Iowa.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Sincerely

Edward G. Weigand
Director
410-209-5265
eweigand@aegonusa.com

Company and Contact

Filing Contact Information

Edward Weigand, Director, Product Filing & Compliance and Licensin	eweigand@aegonusa.com
520 Park Avenue	410-685-5500 [Phone] 5265 [Ext]
Baltimore, MD 21201	410-209-5910 [FAX]

Filing Company Information

Stonebridge Life Insurance Company	CoCode: 65021	State of Domicile: Vermont
29 South Main Street	Group Code: 468	Company Type: Life and Health
Rutland, VT 05701-5014	Group Name:	State ID Number:
(410) 685-5500 ext. [Phone]	FEIN Number: 03-0164230	

Filing Fees

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Fee Required?	Yes
Fee Amount:	$110.00
Retaliatory?	No
Fee Explanation:	$50 per Policy + $20 per other form (20 x 3 = 60) = $110
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	$110.00	12/14/2009	32758829

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/17/2009	12/17/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	12/15/2009	12/15/2009	SPI ADMSLH	12/17/2009	12/17/2009

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Disposition

Disposition Date: 12/17/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Form *(revised)*	Group Prescription Drug Coverage Policy	Approved-Closed	Yes
Form	Group Prescription Drug Coverage Policy	Replaced	Yes
Form *(revised)*	Group Prescription Drug Coverage Certificate	Approved-Closed	Yes
Form	Group Prescription Drug Coverage Certificate	Replaced	Yes
Form *(revised)*	Group Application	Approved-Closed	Yes
Form	Group Application	Replaced	Yes
Form *(revised)*	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/15/2009
Submitted Date	12/15/2009
Respond By Date	

Dear Edward Weigand,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Prescription Drug Coverage Policy, SLRX2010GP (Form)
- Group Prescription Drug Coverage Certificate, SLRX2010GC (Form)

Comment:

Refer to the 60-day period under ACA 23-79-137, coverage for all minors for whom the insured has filed a petition to adopt.

Objection 2

- Group Prescription Drug Coverage Policy, SLRX2010GP (Form)
- Group Prescription Drug Coverage Certificate, SLRX2010GC (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 3

- Group Application, SLRX2010GA (Form)

Comment:

Under the Fraud Statement, Arkansas does not allow the language, 'guilty of a felony of the third degree". Arkansas language is outlined under ACA 23-66-503 and Bulletin 7-97.

Objection 4

- Enrollment Form, SLRX2010GE (Form)

Comment:

The Fraud Statement for Arkansas should be consistant with ACA 23-66-503.

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/17/2009
Submitted Date	12/17/2009

Dear Rosalind Minor,

Comments:
Thank you for your Objection Letter dated December 15. In response we offer the following:

Response 1

Comments: OBJECTION 1 Schedule Items: SLRX2010GP - Group Prescription Drug Coverage Policy SLRX2010GC - Group Prescription Drug Coverage Certificate Comments: Refer to the 60-day period under ACA 23-79-137, coverage for all minors for whom the insured has filed a petition to adopt.
Response: We have revised the policy and certificate forms with respect to adopted children. Revisions have been made in the Eligibility and Effective Date section and definition of Dependent. We believe these forms are now compliant with ACA 23-79-137. As a result, we have revised the form numbers: Group Prescription Drug Coverage Policy is now SLRX2010GP.AR and Prescription Drug Coverage Certificate is now SLRX2010GC.AR. The revised forms are included with this Objection Response.

OBJECTION 2 Schedule Items: SLRX2010GP - Group Prescription Drug Coverage Policy SLRX2010GC - Group Prescription Drug Coverage Certificate Comments: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.
Response: We have revised the policy and certificate forms with respect to handicapped dependents. Revision has been made in the definition of Dependent. We believe these forms are now compliant with ACA 23-86-108(4). As a result, we have revised the form numbers: Group Prescription Drug Coverage Policy is now SLRX2010GP.AR and Prescription Drug Coverage Certificate is now SLRX2010GC.AR. The revised forms are included with this Objection Response.

OBJECTION 3 Schedule Items: SLRX2010GA - Group Application Comments: Under the Fraud Statement, Arkansas does not allow the language, 'guilty of a felony of the third degree''. Arkansas language is outlined under ACA 23-66-503 and Bulletin 7-97.
Response: We have revised the group application's fraud warning as outlined in ACA 23-66-503. As a result, we have

revised the form number: Group Application is now SLRX2010GA.AR. The revised form is included with this Objection Response.

OBJECTION 4 Schedule Items: SLRX2010GE - Enrollment Form Comments: The Fraud Statement for Arkansas should be consistant with ACA 23-66-503.
Response: We have revised the enrollment form's fraud warning as outlined in ACA 23-66-503. As a result, we have revised the form number: Enrollment Form is now SLRX2010GE.AR. The revised form is included with this Objection Response.

Related Objection 1

Applies To:

- Group Prescription Drug Coverage Policy, SLRX2010GP (Form)
- Group Prescription Drug Coverage Certificate, SLRX2010GC (Form)

Comment:

Refer to the 60-day period under ACA 23-79-137, coverage for all minors for whom the insured has filed a petition to adopt.

Related Objection 2

Applies To:

- Group Prescription Drug Coverage Policy, SLRX2010GP (Form)
- Group Prescription Drug Coverage Certificate, SLRX2010GC (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Related Objection 3

Applies To:

- Group Application, SLRX2010GA (Form)

Comment:

Under the Fraud Statement, Arkansas does not allow the language, 'guilty of a felony of the third degree". Arkansas language is outlined under ACA 23-66-503 and Bulletin 7-97.

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Related Objection 4

Applies To:

- Enrollment Form, SLRX2010GE (Form)

Comment:

The Fraud Statement for Arkansas should be consistant with ACA 23-66-503.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Prescription Drug Coverage Policy	SLRX2010GP.AR		Policy/Contract/Fraternal Certificate	Initial		43.090	SLRX2010GP_AR.PDF
Previous Version							
Group Prescription Drug Coverage Policy	*SLRX2010GP*		*Policy/Contract/Fraternal Certificate*	*Initial*		*43.090*	SLRX2010GP.PDF
Group Prescription Drug Coverage Certificate	SLRX2010GC.AR		Certificate	Initial		44.240	SLRX2010GC_AR.PDF
Previous Version							
Group Prescription Drug Coverage Certificate	*SLRX2010GC*		*Certificate*	*Initial*		*44.240*	SLRX2010GC.PDF
Group Application	SLRX2010GA.AR		Application/Enrollment Form	Initial		45.010	SLRX2010GA_AR.PDF
Previous Version							
Group Application	*SLRX2010GA*		*Application/Enrollment Form*	*Initial*		*45.010*	SLRX2010GA.PDF

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*		
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*		
Company Tracking Number:	*GH AR0052015F01*				
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*		
Product Name:	*Prescription Drug*				
Project Name/Number:	*Prescription Drug/GH AR0052015F01*				

Enrollment Form	SLRX2010GE.AR	Application/Enrollment Form	Initial	44.220	SLRX2010GE_AR.PDF

Previous Version

Enrollment Form	*SLRX2010GE*	*Application/Enrollment Form*	*Initial*	*44.220*	SLRX2010GE.PDF

No Rate/Rule Schedule items changed.

We hope this satisfies your concerns and review of this submission can continue. If you need any additional information please let me know.

Edward Weigand
410-209-5265
eweigand@aegonusa.com

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/17/2009	SLRX2010GP.AR	Policy/Contract/Fraternal Certificate	Group Prescription Drug Coverage Policy	Initial		43.090	SLRX2010GP_AR.PDF
Approved-Closed 12/17/2009	SLRX2010GC.AR	Certificate	Group Prescription Drug Coverage Certificate	Initial		44.240	SLRX2010GC_AR.PDF
Approved-Closed 12/17/2009	SLRX2010GA.AR	Application/Enrollment Form	Group Application	Initial		45.010	SLRX2010GA_AR.PDF
Approved-Closed 12/17/2009	SLRX2010GE.AR	Application/Enrollment Form	Enrollment Form	Initial		44.220	SLRX2010GE_AR.PDF

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**
(Hereafter called we, us or our)

Policyholder:	**[ABC Employer]**
Policy Number:	**[A12345]**
Effective Date:	**[01/01/2010]**
First Policy Anniversary:	**[01/01/2011]**
Subsequent Policy Anniversaries:	**[01/01 each subsequent year thereafter]**
State or Other Jurisdiction of Issue:	**[State]**

We agree to insure the eligible persons described in this Policy. We will do this while this Policy stays in force. We agree to pay the benefits of this Policy to the persons insured. Details of the benefits are shown in this Policy.

The Policyholder has applied for this Policy and understands that the required premium must be paid to get the insurance and keep it in force.

When This Policy Will Take Effect
This Policy will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date above, its date of issue.

IN WITNESS WHEREOF, we have signed this policy at Rutland, Vermont.

Craig D. Vermette
Secretary

Marilyn Carp
President

TABLE OF CONTENTS

GROUP PRESCRIPTION DRUG COVERAGE POLICY

THIS POLICY PROVIDES LIMITED COVERAGE. READ IT CAREFULLY.
Non-Participating

INTRODUCTION

In consideration of the premium payments in the amounts and at the times provided, we agree to underwrite the coverage subject to the terms and conditions set forth in this Policy which includes the Group Application attached to this Policy, and fully incorporated herein by reference.

The entire contract includes this Policy, and the Application, any amendments, any riders, and any attachments, together with the Enrollment Forms.

We consider any statement made by a Covered Person or the Policyholder, in the absence of fraud, to be a representation and not a warranty. No statement will be used to avoid the insurance, reduce benefits, or deny a claim unless: the statement is signed and in writing; and a copy of that statement is given to the Covered Person or Beneficiary.

This Policy may be changed at any time by a written agreement between the Policyholder and us. Only our executive officers can change this Policy. The agent does not have the authority to make a promise or statement that binds us. The agent may not accept any late premiums or extend the due date of any premium.

ELIGIBILITY AND EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Eligible Person

An Eligible Person who has met all eligibility requirements of the Policyholder prior to the Effective Date of this Policy may request enrollment during the enrollment period that precedes the Effective Date of this Policy. An Eligible Person who does not enroll during this period will be considered a Late Enrollee. This enrollment period is determined between us and the Policyholder.

After the Effective Date of this Policy, an Eligible Person who does not request enrollment during the following time periods or during a special enrollment period will be considered a Late Enrollee:

1. if this Policy has a Waiting Period, enrollment must be requested no later than **[**30-60**]** days after the end of the Waiting Period;
2. if this Policy does not have a Waiting Period, enrollment must be requested no later than **[**30-60**]** days after the date of hire.

Enrollment is made by completing the enrollment process, as specified. An Eligible Person may enroll for **[**single, Eligible Person and Spouse, Eligible Person and Dependent, or Eligible Person and family. "Single" covers the Eligible Person only. "Family" covers the Eligible Person, Spouse, and his or her eligible Dependents.**]** An Eligible Person cannot also enroll as a Dependent under this Policy.

A person is eligible if the person is included in an Eligible Class listed in the Application and the person is:

1. performing all the normal duties of the persons job at the normal place of business of the Policyholder;
2. working in an Eligible Class shown in the Application;
3. working the minimum required hours at the normal place of business of the Policyholder;
4. **[**if the person is retired from the Policyholder, under age 65 and not enrolled in Medicare; and**]**
5. the person does not have an insurance plan that provides drug benefits.

A person shall cease to be an Eligible Person on the first day of the month following any month in which the number of hours worked falls below the minimum required hours **[**or the Eligible Person reaches age 65 and becomes enrolled in Medicare**]**.

Eligible Dependent

If this Policy provides for family coverage, an Eligible Person may request enrollment of his or her Dependents:

1. at the time the Eligible Person requests enrollment for himself or herself; or
2. when the Eligible Person acquires a new Dependent; or
3. during a special enrollment period.

Proof of the Dependent relationship may be required by us. A Dependent that is not enrolled as described above will be considered a Late Enrollee. A Dependent cannot be enrolled prior to the date the Eligible Person has enrolled for coverage under this Policy.

A person may be enrolled as a Dependent if he or she is:

1. the Eligible Person's Spouse; or
2. the Eligible Person's Dependent child.
3. **[**the Eligible Person’s Dependent Domestic Partner and the children of the Domestic Partner. A person may be enrolled as a Domestic Partner, or the Domestic Partner’s children may be enrolled, if he or she provides us with a copy of a valid Declaration of Domestic Partnership that has been filed with the Secretary of State or has filed an Affidavit of Domestic Partnership with us

and is meeting the requirements set forth by us for Domestic Partnership coverage and meets the definition of Dependent as defined**]**.

If a court or administrative order requires the Eligible Person to provide health care coverage for his or her child and this Policy provides for family coverage, we will:
1. Allow the Eligible Person to enroll such child under family coverage if the child is otherwise eligible and not apply any enrollment period restrictions; or
2. Allow the child's other parent to enroll the child if the Eligible Person fails to enroll the child for family coverage.

Dependents are eligible if:
1. the Eligible Person is in a class that qualifies for Dependent benefits; and
2. the Eligible Person makes a written request giving any information we may require; and
3. the Dependent is not in an Eligible Class.

A person may not be covered more than once under this Policy at the same time. If both husband and wife are covered under this Policy, either, but not both, may elect to cover their eligible Dependent children.

Effective Date of Individual Coverage – Eligible Person
Coverage for an Eligible Person will take effect on the later of:
1. the Effective Date of this Policy; or
2. the **[**first day of the month that next follows the**]** date he or she completes the Waiting Period, if any, as long as enrollment is requested within 31 days after the end of the Waiting Period. If the Waiting Period ends on the first day of the month, coverage will begin on that day, if he or she enrolls during the Waiting Period; or
3. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

The Eligible Person must complete the enrollment process. If the Eligible Person is required to pay all or part of the premium for coverage, the Eligible Person must acknowledge the Eligible Person's permission to the Policyholder to withhold such premium from the Eligible Person's pay.

[Waiting Period
The Waiting Period for an Eligible Person who is not a Late Enrollee is **[**30-60**]** days. The Waiting Period will begin **[**on the employee's date of hire or the date the employee qualifies as an Eligible Person**]**. A Late Enrollee can only enroll during the Policyholder's annual enrollment period, which is held once each calendar year and is held open for **[**30-90**]** consecutive days.**]**

Effective Date of Individual Coverage – Eligible Dependent
Coverage for a Dependent will take effect on the later of:
1. the date the Eligible Person's coverage with us begins; or
2. the day the Eligible Person enrolls his or her Dependent, if enrollment is requested within 31 days of the date the Dependent is acquired; or
3. the date specified in the Special Enrollments section; or
4. the date the Eligible Person acquires that new Dependent if the Eligible Person has family coverage at that time and no additional premium is required; or
5. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

The above provisions do not apply to newborn children, adopted children, children placed for adoption, and children for whom coverage is ordered by a court. Requirements for those children are

described in the following sections. In no event will coverage for a Dependent begin prior to the date coverage begins for the Eligible Person.

Newborn Children.
Coverage for the newborn child of an Eligible Person or Spouse will take effect on the later of:
1. the date coverage for the Eligible Person begins with us; or
2. the moment of birth of the newborn. Coverage is provided for 31 days from the date of birth. In order to continue coverage beyond the 31 day period, the Eligible Person must enroll the child within 31 days of the date of birth and pay any required additional premium. Any required premium must be paid when due from the date of birth. If the enrollment and premium payment procedures are not followed, coverage will not continue beyond the 31 day period.

Adopted Children.
Coverage for a child adopted by or for which a petition to adopt has been filed by an Eligible Person will take effect on the later of:
1. the date coverage for the Eligible Person begins with us; or
2. the date of the filing of the petition for adoption if the Eligible Person applies for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and enrollment for coverage is filed within 60 days after the birth of the child.

Court Ordered Coverage.
If a child of the Eligible Person is enrolled as the result of a court order or administrative order, coverage for such child shall take effect on the date of enrollment once the required premium, if any, has been paid.

Dependent Status Change.
The Eligible Person must inform us or the Policyholder within 31 days of any Dependent change in family status.

Dependent Enrollment
The Eligible Person must complete the enrollment process which includes giving the information we require for all Dependents and authorizing the Policyholder to make payroll deductions toward the cost of Dependent's coverage (if applicable). This enrollment process must be completed prior to the expected birth of a child. The Eligible Persons must then notify us upon the birth of a child. If the Eligible Person did not elect Dependent's coverage before the birth of a child, coverage on that child will not be denied, if we are notified in writing of the birth of such child and the Policyholder is authorized to make the required payroll deductions toward the cost of Dependent's coverage, within 31 days of the date of birth. If Dependent coverage is already available for one Dependent, more Dependents later acquired will be added as of the date such Dependent is acquired. However, we require notification of additional Dependents to assure accurate claims handling and billing.

Special Enrollments
If an Eligible Person declines coverage or declines coverage for his or her Dependents because of other coverage, the Eligible Person or the Dependents may enroll for coverage in the future during the special enrollment period described in paragraph A below.

In addition, if the Eligible Person acquires a new Dependent due to marriage, birth, adoption, placement for adoption **[**or new Domestic Partnership**]**, the Eligible Person and Dependents may enroll for coverage during the special enrollment period described in paragraph B below.

A. Special Enrollment Period - Loss of other coverage:
If an Eligible Person or his or her Dependents:
1. failed to enroll when first eligible for coverage;
2. lose other health coverage; and
3. are otherwise eligible for coverage under this Policy,

the Eligible Person or Dependents may enroll for coverage under this Policy, but only if the following conditions are met:
1. the person was covered under a health plan at the time coverage under this Policy was first offered to the person;
2. the person stated in writing the reason for declining coverage was due to coverage under another health plan;
3. If the other health coverage was:
   (a) COBRA continuation coverage, the COBRA continuation coverage has been exhausted for reasons other than failure to pay timely premiums or for cause; or
   (b) other than COBRA continuation coverage, the coverage was either terminated due to loss of eligibility for coverage or the current or former employer terminated contributions towards the other coverage. Loss of eligibility for coverage includes a loss due to legal separation, **[**dissolution of Domestic Partnership,**]** divorce, death, termination of employment or reduction in the number of hours of employment. Loss of eligibility does not include loss due to failure to pay timely premiums or termination of coverage for cause; and
4. The person requests enrollment under this Policy not later than 30 days after the date the other coverage ended or the employer's contributions terminated.

Coverage under this Policy will become effective on the first day of the month following the date we receive the completed request for enrollment; or on an earlier date, as agreed to by us.

B. Special Enrollment Period - Change in Family Status
If an Eligible Person or his or her Dependents:
1. failed to enroll when first eligible for coverage;
2. are otherwise eligible for coverage under this Policy; and
3. the Eligible Person acquires a Dependent through marriage, **[**Domestic Partnership,**]** birth, adoption, or placement for adoption,

We will provide a special enrollment period for coverage as described below.
The special enrollment period is for 30 days and begins on the later of:
1. the date Dependent Coverage is made available under this Policy; or
2. the date of marriage or termination of marriage, **[**Domestic Partnership or termination of Domestic Partnership,**]** birth, adoption or placement for adoption.

During the special enrollment period, the Eligible Person may request enrollment for single coverage or family coverage for eligible Dependents who are not already enrolled under this Policy.
If enrollment is requested during this special enrollment period, coverage will be effective:
1. in the case of marriage **[**or Domestic Partnership**]**, on the first of the month following the date we receive the completed request for enrollment; or
2. in the case of a Dependent's birth, on the date of such birth; or
3. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Reinstatement after Release from Active Duty
If coverage ends due to a Covered Person being called or ordered to active duty as a reservist, such coverage will be reinstated without any Waiting Period when the employee returns to Eligible Person status or when the Dependent is no longer on active duty.

Reinstatement after Termination of Employment

If coverage ends due to termination of employment and the employee later becomes employed by the Policyholder, he or she must meet all requirements of a new employee before coverage will become effective.

DEFINITIONS

Throughout this Policy, when a term which has been capitalized, its meaning may be found in this section.

AGE
Age at last birthday.

APPLICATION
A form completed by Policyholder in applying for coverage under this Policy.

AWP
The average wholesale price of the Covered Drug, as set forth in the current price list in nationally recognized sources determined by Pharmacy Benefit Manager.

BENEFIT
The dollar amount payable by us to a Claimant under this Policy.

BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

CLAIMANT
A person making a claim under this Policy.

COMPOUND PRESCRIPTION
A prescription that meets the following criteria: two or more solid, semisolid, or liquid ingredients, at least one of which is a Covered Drug, that are weighed or measured then prepared according to the Prescriber's order and the Pharmacist's art.

CO-PAYMENT
The amount a Covered Person must pay for each Prescription or authorized refill. This amount, if any, is shown on the Plan Benefit Schedule in the Prescription Drug Benefits Provision and must be paid to the Provider at the time the services are received.

[COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

COVERED DRUGS
All FDA-approved, Legend Drugs including Generic Drugs, Brand-name Drugs, **[**and**]** Specialty Drugs**[**, Preferred Brand-name Drugs,**][** Non-Preferred Brand-name Drugs,**][** Covered Brand-name Drugs,**][** and**][** Non-Covered Brand-name Drugs**]** (except those listed in the General Exclusions and Limitations section of this Policy) that are prescribed by a Prescriber. The list of Covered Drugs is subject to periodic review and modification. The latest list of Covered Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

COVERED PERSON
An Eligible Person or a Dependent of the Eligible Person, who has enrolled for coverage and for whom premium has been paid to us, so long as coverage of such person under this Policy is in effect.

DEPENDENT
A person who may become covered or is entitled to benefits under this Policy and must be verified by the Policyholder if they are one of the following:
An Eligible Person's:
1. Spouse (if not legally separated or divorced from the Eligible Person).
2. **[**Domestic Partner.**]**
3. A child from the moment of birth, until the end of the calendar year that the child attains Age 19.
4. A child who is a student may be covered until the end of the calendar year that the child attains Age 25 provided such child is:
   (a) A Full-Time Student **[**or part-time student**]** or living in the Eligible Person's household; and
   (b) More than 50% dependent on the Eligible Person for support and maintenance.
   (c) Proof of the child's enrollment as a student must be submitted to us.
5. Handicapped child who has attained either limiting Age shown above, if such child is:
   (a) Mentally retarded or physically incapable of earning their own living; and
   (b) Dependent on the Eligible Person for support and maintenance; and
   (c) Was covered on the day immediately prior to attaining the limiting Age.

Children include a stepchild, adopted child, a child under the charge, care and control of the Eligible Person whom the Eligible Person has filed a petition to adopt, or a child under the guardianship of the Eligible Person or the Eligible Person's Spouse who are dependent upon the Eligible Person for support or a child for whom the Eligible Person is required to provide coverage by a court or administrative order. A foster child or a child who is a ward of the court is not considered to be a Dependent. A Dependent or Domestic Partner cannot also be enrolled as an Eligible Person under this Policy.

DISCOUNTED PRICE
The price that the Pharmacy Benefit Manager has negotiated for the medication, resulting in a price lower than AWP.

[DOMESTIC PARTNER
Two individuals who, together, each meet all of the following criteria set forth below:
1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the domestic partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
   (a) living together as a couple;
   (b) mutual support of each other;
   (c) mutual caring and commitment to each other;
   (d) mutual fidelity;
   (e) mutual responsibility for each other's welfare; and
   (f) joint responsibility for the necessities in life.

8. Have been living together as a couple for at least 6 months prior to obtaining the coverage provided under this Policy.
9. Intend to continue the domestic partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.**]**

ELIGIBLE CLASS
A description of Eligible Persons meeting all eligibility requirements in this Policy that is shown in the Application.

ELIGIBLE PERSON
An Eligible Person or a person whose employment or whose status with the Policyholder is the basis for eligibility for coverage under this Policy and who meets the enrollment rules. An Eligible Person cannot also be enrolled as a Dependent under this Policy.

EMPLOYEE
A person who is employed by**[**, or retired from and under Age 65 and not enrolled in Medicare**]** and paid by the Policyholder.

[ENROLLMENT PERIOD
The timeframe as defined by this Policy within which an Eligible Person may request coverage under this Policy. The following are the Enrollment Periods available to an Eligible Person under this Policy:
1. Initial enrollment period is a **[**30-90**]** day period after the effective date of this Policy when an Eligible Person may request enrollment for coverage under this Policy.
2. Annual Enrollment Period is the **[**month each calendar year**]** when an Eligible Person may request enrollment for coverage under this Policy.
3. Special Enrollment Period is a **[**30-90**]**-day period, based on qualifying events, when an Eligible Person may request enrollment for coverage under this Policy.**]**

FULL-TIME STUDENT
A person who is enrolled in and attending, on a full-time basis, a recognized course of study or training at: (1) an Accredited high school or vocational school; (2) an Accredited college or university; (3) a licensed technical or trade or similar training school, which offers general education classes. Full-Time Student status is determined by the standards set forth by the school, college or university. A person ceases to be a Full-Time Student at the end of the calendar month during which the person graduates or ceases to be enrolled and in attendance on a full-time basis. A person continues to be a Full-Time Student during periods of vacation established by the school, college, or university if he or she was a Full-Time Student on the day before the start of the vacation period. “Accredited” means the school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S. Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC. We may require proof of Full-Time Student status.

GENERIC DRUG
A multisource Generic Drug set forth in the Pharmacy Benefit Manager’s list of Generic Drugs, as reasonably determined by the Pharmacy Benefit Manager, and that is available in sufficient supply from multiple manufacturers. The list is subject to periodic review and modification. The latest list of Generic Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

LATE ENROLLEE
An Eligible Person or Dependent who has declined coverage under a plan offered by the Policyholder at the time of the initial enrollment period provided under the terms of the plan, and who subsequently

requests enrollment in a plan of that the Policyholder, provided that the initial enrollment period shall be a period of at least **[**30-90**]** days. However, an Eligible Person or Dependent shall not be considered a Late Enrollee if any of the conditions defined in the Special Enrollments Section are applicable.

LEGEND DRUGS
A drug that is required by federal or state law, to be dispensed pursuant to a prescription or order by an authorized Prescriber.

MAIL ORDER PHARMACY
The Pharmacy Benefit Manager's licensed mail order pharmacy subsidiaries, which provide prescription drugs via a mail order service.

[NON-COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Covered Brand-name Drug, refer to the latest list of Non-Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

[NON-PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Preferred Brand-name Drug, refer to the latest list of Non-Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

PARTICIPATING RETAIL PHARMACY
A retail pharmacy that has entered into an arrangement with the Pharmacy Benefit Manager that specifies the terms and conditions of the pharmacy's participation, including the rates that the Pharmacy Benefit Manager will pay the pharmacy.

PHARMACIST
An individual who is currently licensed in accordance with applicable law and regulations to engage in the practice of pharmacy.

PHARMACY
A site, properly licensed in accordance with applicable law and regulations, where drugs are dispensed or pharmaceutical care is provided by a licensed pharmacist.

PHARMACY BENEFIT MANAGER
The entity that administers and manages this generic prescription drug coverage program and, in connection therewith, has established networks of participating retail pharmacies and operates a system for the processing fulfillment and payment of claims for prescription drugs furnished by such pharmacies.

[PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

PRESCRIBER
A duly licensed health care practitioner who is authorized by law to write prescriptions or medication orders intended for the treatment or prevention of disease.

SPECIALTY DRUGS
Pharmaceutical products that are reasonably determined by the Pharmacy Benefit Manager to be biotechnological in nature and are used to treat certain conditions. The list is subject to periodic review and modification. The latest list of Specialty Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

SPOUSE
The legal husband or wife of the Eligible Person as recognized by state law.

USUAL AND CUSTOMARY
The price that a Pharmacy charges a customer who does not have any form of prescription drug coverage.

[WAITING PERIOD
The period of time required by the Policyholder which must pass before coverage begins under this Policy for an Eligible Person.**]**

PRESCRIPTION DRUG BENEFITS PROVISION

The following Plan Benefit Schedule**[**s**]** describe**[**s**]** what the Covered Person will pay for Covered Drugs through the Pharmacy Benefit Manager or at a Participating Retail Pharmacy. Covered Drugs include all FDA-approved, Legend Drugs (except those listed in the General Exclusions and Limitations section) that are prescribed by a Prescriber.

Plan Benefit Schedule[s]

[[Plan 1 – [Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 2 – [Super Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 0: **[**$0**]** Co-payment Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 0: **[**N/A**]** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 3 – [Value Generic with Preferred Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Preferred Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-3000**]** Individual / **[**$0-6000**]** Family**]** **[**Monthly Plan Maximum: **[**$0-250**]** Individual / **[**$0-500**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any

	Brand-name cost differential**]**
Specialty and Non-Preferred Brand-name Drugs	**[**100%**]** of a discounted amount

[[Plan 4 – [Value Generic with Managed Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Covered Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-3000**]** Individual / **[**$0-6000**]** Family**]** **[**Monthly Plan Maximum: **[**$0-250**]** Individual / **[**$0-500**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any Brand-name cost differential**]**
Specialty and Non-Covered Brand-name Drugs	**[**100%**]** of a discounted amount

The list of Generic, Brand-name and Specialty Drugs, and any additional drug and/or Tier, has been agreed to by the Policyholder, the Pharmacy Benefit Manager and us. The list is subject to periodic review and modification. The list can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

Participating Retail Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Mail-Order Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-

payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**

- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Filling a Prescription at a Participating Retail Pharmacy

In order to fill a prescription at a Participating Retail Pharmacy, the Covered Person will submit the Covered Person's prescription along with the Covered Person's prescription drug ID card to the Pharmacist at the Participating Retail Pharmacy. The Pharmacist will dispense the Covered Drug to the Covered Person and charge the Covered Person the appropriate amount.

Filling a Prescription at the Mail Order Pharmacy

In order to fill a prescription at the Mail Order Pharmacy, the Covered Person will fill-out a Mail Order Pharmacy order form and mail the completed form, the prescription, and the Covered Person's payment option to the Mail Order Pharmacy. In certain circumstances, the Covered Person may also have the Covered Person's Prescriber fax the Covered Person prescription to Mail Order Pharmacy. The Covered Person's prescription will be filled and the Covered Person will be charged the appropriate amount in accordance with the payment option the Covered Person has selected. Once filled, the prescription will be delivered to the Covered Person's home or office, by mail, usually within **[**10-25**]** days after Mail Order Pharmacy receives the Covered Person's initial prescription and **[**7-15**]** days after Mail Order Pharmacy receives the Covered Person's re-fill prescription. Mail Order Pharmacy will dispense Covered Drugs to the Covered Person in accordance with applicable law and regulations in the state in which Mail Order Pharmacy is located. Any prescriptions that are not dispensed will be returned to the Covered Person with an explanation as to why it could not be dispensed in accordance with Mail Order Pharmacy's standard operating procedures.

GENERAL EXCLUSIONS AND LIMITATIONS

We will not pay for:

1. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after 1 year from the Prescriber's original order.
2. Any quantity of medications dispensed for more than a **[**30-60**]**-day supply from a Participating Retail Pharmacy or **[**90-120**]**-day supply through the Pharmacy Benefit Manager.
3. Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the Covered Person.
4. Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
5. Federal and Non-Federal Legend Non-Drugs.
6. Charges for the administration or injection of any drug.
7. Substance abuse treatment.
8. Therapeutic devices and appliances.
9. Prescriptions for household pets.

[10. Medications not dispensed by a Participating Retail Pharmacy or the Pharmacy Benefit Manager.**]**

[11. The following drugs (both the Brand-name Drugs or Generic Drugs) are only available at the Brand-Name drugs pricing noted in the Plan Benefit Schedule section:

- Single source generic drugs i.e., those available from only a single manufacturer
- Impotence and erectile function medications
- Smoking deterrents (except Zyban®)
- Anti-obesity medications
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.**]**

[12. Isotretinoin products (Brand-name Drugs and Generic Drugs) including Accutane®, Amnesteem®, Sotret® and Claravis™.**]**

[13. Over-the-counter drugs and vitamins.**]**

[14. Ostomy supplies.**]**

[15. Non-systemic contraceptives, devices, implants, and injections.**]**

[16. Compound prescription drug products.**]**

[17. Topical fluoride products.**]**

[18. GlucoWatch®/GlucoWatch® Sensors.**]**

[19. Drugs labeled "Caution—limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.**]**

[20. Fertility Agents (except those Specialty Drugs which may be subject to the Generic Drug Benefits section).**]**

[21. Injectable Medications (except Brand-name Insulin & those which are Specialty Drugs subject to the Prescription Drug Benefits Provision).**]**

[22. Biologicals, Immunization Agents, Vaccines, Allergy Sera, Blood or Blood Plasma Products (except those Specialty Drugs which may be subject to the Prescription Drug Benefits Provision).**]**

[23. Other drugs as determined by us and the Pharmacy Benefits Manager. We will provide 60 days notice before adding a drug to this list of exclusions.**]**

Benefits are not provided for expenses which result directly or indirectly, wholly or partly from:

1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.
2. Declared or undeclared war or acts thereof.
3. Serving on full-time active duty in any armed forces of any country or international authority (any premium paid will be returned by us pro-rata for any period of active-full time duty).
4. Any Workers' Compensation Act, Occupational Disease law or similar law under which benefits were paid or received by the Covered Person.
5. The Covered Person operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
6. Charges for which:
   - there is no legal obligation to pay, or
   - no charge is made, or
   - in the absence of coverage, no charge would be made.
8. Charges incurred after coverage terminates under this Policy.
9. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
10. Charges for services which are not related to and consistent with the treatment of the Covered Person.

CLAIMS PROVISION

Direct Claim Process

The Covered Person will be able to submit a direct claim to the Pharmacy Benefit Manager in the event that the Covered Person pays the Usual and Customary price for the Covered Person's first purchase of a Generic Drug at a Participating Retail Pharmacy. For example, for the Covered Person's first purchase of Generic Drug, the Covered Person may forget to submit the Covered Person's prescription drug ID card to the Participating Retail Pharmacy, thus causing the Participating Retail Pharmacy to charge the Covered Person its Usual and Customary price for the Generic Drug (rather than the applicable Co-payment), In such event, the Covered Person may submit a direct claim to the Pharmacy Benefit Manager for reimbursement. The Covered Person may submit a direct claim by completing a direct claim form, with the receipt attached, and mailing it to Pharmacy Benefit Manager for processing and approval. Reimbursement will be based on the amount the benefit would have paid, less any applicable Co-payment.

Coordination of Benefits

There will be no Coordination of Benefits for allowed pharmacy charges between this Policy and another pharmacy/medical plan in which the Covered Person may be enrolled.

Notice of Claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to the Pharmacy Benefits Manager at their home office or to the Pharmacy Benefits Manager's agent. Notice should include the name of the Covered Person and the policy number.

Proof of Loss

If it is necessary to submit a direct claim form, it must be given to the Pharmacy Benefit Manager within 90 days of the claim. If it was not possible for the claim form to be given within 90 days, We will not deny the claim because of late filing, provided proof was given as soon as reasonably possible. In any case, the direct claim form must be sent no later than 1 year from the time specified, unless the Covered Person is legally incapacitated.

Payment Of Claims

Benefits payable under this Policy will be directly to: (a) the Covered Person or (b) the Covered Person's legally appointed guardian if the Covered Person is not legally able to accept such benefits. In the event the Covered Person dies we will pay any benefits due and not assigned to the Covered Person's estate. Any payment made in good faith fully discharges us to the extent of that payment.

Time of Payment of Claims

After receiving written proof of loss, we will pay monthly all benefits then due. Benefits for any other loss covered by this Policy will be paid as soon as we receive proper written proof.

PAYMENT OF PREMIUMS

Computation of Premiums. Each monthly premium will be calculated on the basis of our record as to the number of Covered Persons in each coverage classification at the time of calculation, at the premiums then in effect.

Adjustments to Premiums. Retroactive adjustments may be made for any additions or terminations of Covered Persons and changes in coverage classification not stated in our records at the time the premium charges are calculated by us. If an addition is made effective before the **[**16th**]** day of the month then a full month's Premium will be charged. If an addition is made effective on or after the **[**16th**]** day of the month then no premium will be charged for that month. If a termination is made effective before the **[**16th**]** day of the month then no premium will be charged for that month. If a termination is made effective on or after the **[**16th**]** day of the month then a full month's premium will be charged for that month. The Policyholder is required to notify us of any changes using the appropriate paper or electronic notification. No retroactive credit will be given for any change occurring more than **[**30, 60, 90**]** days before our receipt of such notification. Claims paid after the termination date due to the retroactive termination will be recouped from the appropriate parties.

We have the right to change the premiums as follows:

1. on each Policy renewal date. We will give the Policyholder written notice of the change in premium rates at least **[**31 days**]** before the effective date of the change; and
2. on any date that the terms of this Policy are amended. We will give the Policyholder written notice of the change in Premium rates at least **[**31 days**]** before the effective date of the change**[**.**][**; and
3. on any date that the number of Covered Persons changes **[**by 10% or more**]**. We will give the Policyholder written notice of the change in premium rates.**]**

Payment. All premiums, including adjustments, must be paid to us by the Policyholder at our Home Office. These premiums are due as shown on the first page of this Policy. Once a premium is paid, insurance will be continued through the day prior to the next premium due date. The Policyholder may ask for a mode of payment that is one, two, four, or twelve times a year. This request must be approved by us. The Policyholder agrees to collect any employee contribution towards the premium.

Grace Period. A grace period of 31 days will be granted for the payment of premiums, during which this Policy will continue in force. In no event will any grace period extend beyond the date this Policy ends. The Policyholder will be liable to us for the premium payment that accrues for any period that this Policy is in force, including the grace period.

Late Payment Charge. If we do not receive any premium payments due under this Policy on or before the due date, the unpaid amount is subject to a late payment charge at the Monthly Interest Rate of **[**1,2,3,4,5**]** %. The Policyholder's payment of this late payment charge is not in lieu of automatic termination of this Policy as provided in Grace Period Section. We are entitled to both the unpaid premium payments and the late payment charge. We may, without prejudice, waive the late payment charge at any time. The Policyholder will also be responsible for the payment of all costs and expenses, including reasonable attorney's fees, incurred by us to collect any unpaid premiums from the Policyholder.

Reinstatement. Regardless of any contrary terms, if the Policyholder makes the proper premium payment plus late payment charges payable under this Policy to us after the end of the grace period, we may, at our sole option, reinstate this Policy without a lapse in coverage.

PARTICIPATION REQUIREMENTS

The Policyholder is enrolled with minimum participation requirements expressed as **[**10-50**]** percent of eligible Employees with a minimum of **[**10-25**]** Employees enrolled.

END OF THIS POLICY

Term of this Policy. This Policy will remain in force from the stated effective date and will continue under the same terms and conditions from year to year, unless it is ended or changed through an amendment or rider as provided in this Policy. The end of this Policy will not relieve the Policyholder from any obligation imposed upon it by the terms of this Policy for covered services rendered before the date this Policy ends, or relieve the Policyholder from any obligation incurred prior to the date this Policy ends. If this Policy ends, it will be the Policyholder's obligation to notify the Policyholder's Covered Persons regardless of the reason this Policy ends, except if we cease to offer this type of coverage.

Termination by Us. We may end this Policy at the end of any month by giving notice to the Policyholder for the following reasons only:

1. Nonpayment of Premiums. The Policyholder has failed to pay the required premiums, or has failed to pay premiums on a timely basis as set forth in the Premium Payment Section.
2. Fraud. The Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with coverage.
3. Violation of participation or the Policyholder's contribution requirements. The Policyholder has failed to comply with a material term of this Policy relating to any participation or contribution requirements. We will give the Policyholder **[**30-60**]** days prior written notice.
4. Termination of Coverage. We are ceasing to offer this type of coverage in the Policyholder's market. If we cease offering this type of coverage in the Policyholder's market, we will:
   a. give 90 days prior notice to the Policyholder and Covered Persons; and
   b. offer the Policyholder the option to purchase other coverage currently being offered by us; and
   c. act uniformly without regard to the Policyholder's claims experience or to any health status-related factor relating to any Covered Person covered or new employees and dependents who may become eligible for coverage.

Termination by the Policyholder. The Policyholder may end this Policy at any time by giving written notice to us **[**30-60**]** days prior to the requested termination date. All notices of termination should be sent via certified letter. In the event of termination, we will return promptly the unearned portion of any premium paid. Termination will be without prejudice to any claim originating before the effective date of termination.

Termination of Individual Coverage.

Coverage for a Covered Person shall automatically end on the earliest of the dates specified below:

1. the date this Policy is terminated;
2. the last day of the month in which the Eligible Person no longer meets eligibility requirements, unless an alternative date is otherwise stated in this Policy. The Eligible Person must notify us in writing within **[**30-60**]**1 days of a change, or termination of court or administrative ordered coverage;
3. the end of the period for which premium was last remitted for a Covered Person by the Policyholder if the Policyholder fails to remit premium when due;
4. the end of the period for which the last premium contribution is made, if premium contributions by the Eligible Person are required;
5. the date the Policyholder terminates the coverage for the Eligible Person's unit or class;
6. the last day of the month in which the Eligible Person is disabled, laid-off or on leave of absence.
7. the date the Eligible Person replaces this coverage with another health benefit plan;
8. the date specified by us in written notice to the Covered Person that all coverage under this Policy will end because the person misused his or her identification card, including but not limited to permitting a person not authorized by us to use the Identification Card to obtain covered services.

In addition, coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder.

Dependent Coverage, if applicable, will cease on the earliest of the following dates:
1. the date the Eligible Person is no longer in a Eligible Class for Dependent coverage; or
2. the date the Eligible Person or the Policyholder cease premium payments for Dependent coverage; or
3. the date we cancel all Dependent coverage under this Policy; or
4. the date the Eligible Person's coverage ceases.

In addition, Dependent's coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked by the Eligible Individual falls below the minimum required hours.

COBRA Coverage
A Covered Person whose coverage under this Policy would otherwise end may be entitled to elect continuation coverage under federal law or state law.

1. General Requirements:

   Continuation Coverage under COBRA applies only to employers which are subject to the provisions of COBRA. The Covered Person should contact the Policyholder's plan administrator to determine if the Covered Person is eligible to continue coverage under COBRA. We are not obligated to provide continuation coverage to a Covered Person if the Policyholder or its designated plan administrator fails to perform its duties under federal law. These duties include but are not limited to:
   (a) notifying the Covered Person in a timely manner of the right to elect continuation coverage; and
   (b) notifying us in a timely manner of the Covered Person's election of continuation coverage.

   We are not the Policyholder's designated plan administrator and do not assume any duties of a plan administrator pursuant to federal law.

   If the Covered Person chooses continuation coverage under a prior plan which was replaced by this Policy, the Covered Person's continued coverage shall terminate as scheduled under the prior plan or in accordance with the terminating events stated in item 4 below, whichever is earlier;

2. Qualifying events for COBRA Continuation Coverage:

   If the Covered Person's coverage terminates due to one of the following qualifying events, the Covered Person is entitled to continue coverage. The Covered Person may elect the same coverage that the Covered Person had at the time of the qualifying event. Qualifying events are:
   (a) Termination of the Eligible Person from employment with the Policyholder or reduction of hours, for any reason other than gross misconduct; or
   (b) Death of the Eligible Person; or
   (c) Divorce or legal separation from the Eligible Person; or
   (d) A Dependent child's loss of eligibility; or
   (e) Entitlement of the Eligible Person to Medicare benefits; or

(f) For a retired Eligible Person and his or her Dependents, the filing of Chapter 11 bankruptcy by the Policyholder;

3. COBRA Notification Requirements and Election Period:

The Covered Person must notify the Policyholder's designated plan administrator within 60 days of his or her divorce, legal separation or loss of eligibility as a Dependent.

Continuation must be elected by the later of:
(a) 60 days after the Covered Person's qualifying event occurs; or
(b) 60 days after the Covered Person receives notice of the continuation right from the Policyholder's designated plan administrator.

The Covered Person must pay the initial premium due to the Policyholder's designated plan administrator within 45 days after electing continuation. The Covered Person's monthly premium under COBRA may exceed the Group rate;

4. Terminating Events for COBRA Continuation Coverage:

COBRA continuation under this Policy will end on the earliest of the following dates:
(a) 18 months from the date continuation began, if the Covered Person's coverage ended because employment was terminated or hours were reduced. If a Covered Person is disabled at any time during the first 60 days of COBRA coverage, beginning on the day after termination of employment or reduction in hours, continuation coverage may be extended to a maximum of 29 months. Tthe Covered Person must give notice of the Covered Person's disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend coverage beyond 18 months. If the Covered Person provides such notice, the Covered Person's coverage may be extended up to a maximum of 29 months from the date of such qualifying event or until the first month that begins more than 30 days after the date of any final decision that the Covered Person is no longer disabled. If the disabled Covered Person has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29 month disability extension. A Covered Person must provide notice of any final determination that he or she is no longer disabled within 30 days of such determination;
(b) 36 months from the date continuation began for a Dependent whose coverage ended because of the death of the Eligible Person, divorce or legal separation from the Eligible Person, loss of eligibility by a Dependent child or entitlement of the Eligible Person to Medicare benefits, in accordance with qualifying events 2b through 2e above;
(c) The date coverage terminates under this Policy for failure to make timely payment of the premium;
(d) The date coverage is obtained under any other group health plan. If such coverage has a limitation or exclusion with respect to a Covered Person's pre-existing condition, continuation will end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health care except health care which is subject to the pre-existing condition limitation or exclusion. If the other group health plan's pre-existing condition limitations or exclusions cannot be applied because of the restrictions under the Health Insurance Portability and Accountability Act of 1996, then COBRA continuation will end on the date the Covered Person became covered under the other group health plan;
(e) The date the Covered Person becomes entitled to Medicare, except that this will not apply if the coverage was terminated because the Policyholder filed for bankruptcy, in accordance with qualifying event 2f of Section (2) above;

(f) The date this Policy terminates;
(g) The date coverage would otherwise terminate under this Policy.

If the Covered Person's coverage ended because employment was terminated or hours reduced as described in item 2a above, and during the 18 month continuation period a second qualifying event occurs, coverage may be extended up to a maximum of 36 months. The 36 month period starts from the date coverage ended due to the first qualifying event. If the Covered Person is entitled to continuation because the Policyholder filed for bankruptcy, as described in item 2f above and the retired Eligible Person dies during the continuation period, the Dependents are entitled to continue coverage for 36 months from the date of death. Terminating events 4b through 4g shall apply during any extended continuation period.

A Dependent whose continuation coverage terminates because the Eligible Person becomes entitled to Medicare should contact the Policyholder's designated plan administrator for information regarding an extension of continuation coverage for an additional period of time.

[Continuation coverage under COBRA is not available to Domestic Partners, if Domestic Partner coverage is available to the Covered Person.**]**

ADMINISTRATION OF THIS POLICY

Forms. We will supply the Policyholder with a reasonable supply of its forms and descriptive materials for distribution to employees. The Policyholder will give our forms and descriptive materials to any employee who becomes eligible for coverage under this Policy. Group agrees to forward all applicable forms, including Enrollment Forms, and other required information to us within **[**10-20**]** business days of receipt from an employee.

Records. The Policyholder agrees to make payroll and other records directly related to Covered Persons' coverage under this Policy available to us for inspection at our expense, at the Policyholder's office, during regular business hours upon reasonable advance request by us. This Records Section will survive the end of this Policy as needed to resolve outstanding financial or administrative issues under this Policy.

GENERAL PROVISIONS

Conformity with State Statutes. If any part of this Policy does not conform to a statute in the state in which it is issued or delivered, it is amended to conform with the minimum statutes of that state.

Disclosure to Policyholder. At the request of a Policyholder, we may provide summary health information to the Policyholder for purposes of 1) obtaining premium bids, or 2) modifying, amending or terminating this Policy. In addition, if the Policyholder 1) amends its summary plan description and 2) provides certification to us that such amendment has been made, detailed health information may be released without summarizing the information. Additionally, we may disclose to the Policyholder information on whether the individual is participating in this Policy.

Individual Certificates. We will give to the Policyholder a certificate for each employee who is entitled to insurance under this Policy. It explains the main benefits and requirements of this Policy. It lists any limitations on coverage. It tells the Covered Person how to make a claim against this Policy.

Governing Law. This Policy is delivered in and governed by the laws of the state noted on the first page of this Policy.

Legal Actions. No action at law or in equity may begin prior to 60 days after we receive a valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

New Employees. New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible. Completion of the enrollment process or waiver of coverage must be obtained from each employee.

Notice to Policyholder. Written notice given by us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of this Policy, including termination of this Policy and termination of individual coverage under this Policy.

Right to Receive and Release Necessary Information. In implementing and determining the applicability of the terms of this Policy, we may release to, or obtain from, any other insurance company, organization or person any other information with respect to any person which we deem necessary for such purposes. Any person claiming benefits under this Policy is required to furnish us such information and/or cooperation as may be necessary to implement this provision.

Waiver of Rights. If we fail to enforce any provision of this Policy, such failure will not affect our right to do so at a later date, nor will it affect our right to enforce any other provision of this Policy.

Workers' Compensation Not Affected. This Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

Important Notice. If the Policyholder has any questions or concerns about coverage under this Policy or if the Policyholder would like to make any comments or complaints, please call **[**1-800-XXX-XXXX**]**.

[ERISA

If this Policy is being purchased to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. Section 1001 et seq., We are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.**]**

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**
(Hereafter called we, us or our)

CERTIFICATE OF COVERAGE

PRESCRIPTION DRUG COVERAGE

INSURING AGREEMENT

Stonebridge Life Insurance Company has issued a Policy covering certain Eligible Classes of the Policyholder. The benefits of the Policy are described in this Certificate. Final interpretation is governed by the Policy. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy. This Certificate describes the Policy in detail.

NOTICE CONCERNING YOUR CERTIFICATE

The benefits and provisions of the Policy are described in this Certificate. However, you only have the benefits outlined in the Certificate provided Eligibility and Enrollment requirements described herein are satisfied, and any required Premium is paid.

Please read Your Certificate carefully. Keep it in a safe place.

Craig D. Vermilye
Secretary

Marilyn Carp
President

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[CERTIFICATE INFORMATION

Group: [ABC Company] **Group Policy Number: [02-000000]**

Certificate Number: [0000000000]

Covered Person: [John Doe] **Effective Date of Coverage: [mm/dd/yy]**

Spouse: [None] **Effective Date of Coverage: [mm/dd/yy]**

Dependent(s): [None] **Effective Date of Coverage: [mm/dd/yy]]**

INTRODUCTION

This Certificate describes your coverage under Stonebridge Life Insurance Company. This Certificate outlines the terms of your coverage under the Policy signed by the Policyholder. It is not the entire Policy. The Policy and the Group Application are available at the Policyholder's office for your inspection at reasonable times.

How to Use This Certificate. Please read this Certificate carefully. Become familiar with its terms. Many of the Certificate terms are related. Just reading one or two sections may give you a misleading impression. Many terms in this Certificate have special meaning. These words will appear with their first letter capitalized, and are defined in the Certificate. The terms "you" and "your" as used throughout this Certificate mean the Eligible Person. By using these definitions, you will get the clearest picture of what is being said. From time to time, this Certificate will be amended. When that happens, an amendment or rider will be sent to you. Keep the Certificate and any amendments and riders in a safe place for future reference.

Benefits under the Policy are subject to certain limitations and restrictions. In order to optimize benefits, please carefully read and ensure you understand the terms of the Policy, including Prior Notification. If you have any questions, or need further help, please call us at **[**the number on your ID card**]**.

ELIGIBILITY AND EFFECTIVE DATE FOR YOU

Who is eligible?
You are eligible if you are included in an Eligible Class listed in the Application and you are:
1. performing all the normal duties of your job at the normal place of business of the Policyholder;
2. working in an Eligible Class shown in the Application;
3. working the minimum required hours at the normal place of business of the Policyholder;
4. **[**if you are retired from the Policyholder, under age 65 and not enrolled in Medicare; and**]**
5. you do not have an insurance plan that provides drug benefits.

How do I enroll?
If you meet all eligibility requirements of the Policyholder prior to the Effective Date of the Policy you may request enrollment during the enrollment period that precedes the Effective Date of the Policy. If you do not enroll during this period you will be considered a Late Enrollee. This enrollment period is determined between us and the Policyholder.

After the Effective Date of the Policy, if you do not request enrollment during the following time periods or during a special enrollment period you will be considered a Late Enrollee:
1. if the Policy has a Waiting Period, enrollment must be requested no later than **[**31 days**]** after the end of the Waiting Period;
2. if the Policy does not have a Waiting Period, enrollment must be requested no later than **[**31 days**]** after the date of hire.

Waiting Periods are described in this Certificate.

Enrollment is made by completing the enrollment process, as specified. You may enroll for **[**single, Eligible Person and Spouse, Eligible Person and Dependent, or Eligible Person and family. "Single" covers the Eligible Person only. "Family" covers the Eligible Person, Spouse, and your eligible Dependents.**]** You cannot also enroll as a Dependent under the Policy.

When do I cease to be eligible?
You shall cease to be an Eligible Person on the first day of the month following any month in which the number of hours worked falls below the minimum required hours **[**or you reach age 65 and become enrolled in Medicare**]**.

When will I become covered?
Your coverage will take effect on the later of:
1. the Effective Date of the Policy; or
2. the **[**first day of the month that next follows the**]** date you complete the Waiting Period, if any, as long as enrollment is requested within 31 days after the end of the Waiting Period. If the Waiting Period ends on the first day of the month, coverage will begin on that day, if you enroll during the Waiting Period; or
3. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

You must complete the enrollment process. If you are required to pay all or part of the premium for coverage, you must acknowledge your permission to the Policyholder to withhold such premium from your pay.

[Waiting Period
The Waiting Period for an Eligible Person who is not a Late Enrollee is **[**30-60 days. The Waiting Period will begin **[**on your date of hire or the date you qualifies as an Eligible Person**]**. A Late

Enrollee can only enroll during the Policyholder's annual enrollment period, which is held once each calendar year and is held open for **[**30-90**]** consecutive days.**]**

Special Enrollments

If you decline coverage or decline coverage for your Dependents because of other coverage, you or your Dependents may enroll for coverage in the future during the special enrollment period described in paragraph A below.

In addition, if you acquire a new Dependent due to marriage, birth, adoption, placement for adoption **[**or new Domestic Partnership**]**, you and your Dependents may enroll for coverage during the special enrollment period described in paragraph B below.

A. Special Enrollment Period - Loss of other coverage:

If you or your Dependents:

1. failed to enroll when first eligible for coverage;
2. lose other health coverage; and
3. are otherwise eligible for coverage under the Policy,

you or your Dependents may enroll for coverage under the Policy, but only if the following conditions are met:

1. the person was covered under a health plan at the time coverage under the Policy was first offered to the person;
2. the person stated in writing the reason for declining coverage was due to coverage under another health plan;
3. If the other health coverage was:
   (a) COBRA continuation coverage, the COBRA continuation coverage has been exhausted for reasons other than failure to pay timely premiums or for cause; or
   (b) other than COBRA continuation coverage, the coverage was either terminated due to loss of eligibility for coverage or the current or former employer terminated contributions towards the other coverage. Loss of eligibility for coverage includes a loss due to legal separation, **[**dissolution of Domestic Partnership,**]** divorce, death, termination of employment or reduction in the number of hours of employment. Loss of eligibility does not include loss due to failure to pay timely premiums or termination of coverage for cause; and
4. The person requests enrollment under the Policy not later than 30 days after the date the other coverage ended or the employer's contributions terminated.

Coverage under the Policy will become effective on the first day of the month following the date we receive the completed request for enrollment; or on an earlier date, as agreed to by us.

B. Special Enrollment Period - Change in Family Status

If you or your Dependents:

1. failed to enroll when first eligible for coverage;
2. are otherwise eligible for coverage under the Policy; and
3. you acquire a Dependent through marriage, **[**Domestic Partnership,**]** birth, adoption, or placement for adoption,

we will provide a special enrollment period for coverage as described below.

The special enrollment period is for 30 days and begins on the later of:

1. the date Dependent Coverage is made available under the Policy; or
2. the date of marriage or termination of marriage, **[**Domestic Partnership or termination of Domestic Partnership,**]** birth, adoption or placement for adoption.

During the special enrollment period, you may request enrollment for single coverage or family coverage for eligible Dependents who are not already enrolled under the Policy.

If enrollment is requested during this special enrollment period, coverage will be effective:

1. in the case of marriage **[**or Domestic Partnership**]**, on the first of the month following the date we receive the completed request for enrollment; or
2. in the case of a Dependent's birth, on the date of such birth; or
3. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Reinstatement after Release from Active Duty

If coverage ends due to you being called or ordered to active duty as a reservist, such coverage will be reinstated without any Waiting Period when you return to Eligible Person status or when the Dependent is no longer on active duty.

Reinstatement after Termination of Employment

If coverage ends due to termination of employment and the employee later becomes employed by the Policyholder, you must meet all requirements of a new employee before coverage will become effective.

ELIGIBILITY AND EFFECTIVE DATE FOR DEPENDENTS

Is my Dependent eligible?
Dependents are eligible if:
1. you are in a class that qualifies for Dependent benefits; and
2. you make a written request giving any information we may require; and
3. the Dependent is not in an Eligible Class.

A person may not be covered more than once under the Policy at the same time. If both husband and wife are covered under the Policy, either, but not both, may elect to cover their eligible Dependent children.

How do enroll a Dependent?
If the Policy provides for family coverage, you may request enrollment of your Dependents:
1. at the time you request enrollment for yourself; or
2. when you acquire a new Dependent; or
3. during a special enrollment period.

Proof of the Dependent relationship may be required by us. A Dependent that is not enrolled as described above will be considered a Late Enrollee. A Dependent cannot be enrolled prior to the date you have enrolled for coverage under the Policy.

A person may be enrolled as a Dependent if he or she is:
1. your Spouse; or
2. your Dependent child.
3. **[**your Dependent Domestic Partner and the children of the Domestic Partner. A person may be enrolled as a Domestic Partner, or the Domestic Partner's children may be enrolled, if he or she provides us with a copy of a valid Declaration of Domestic Partnership that has been filed with the Secretary of State or has filed an Affidavit of Domestic Partnership with us and is meeting the requirements set forth by us for Domestic Partnership coverage and meets the definition of Dependent as defined**]**.

If a court or administrative order requires you to provide health care coverage for your child and the Policy provides for family coverage, we will:
1. Allow you to enroll such child under family coverage if the child is otherwise eligible and not apply any enrollment period restrictions; or
2. Allow the child's other parent to enroll the child if you fail to enroll the child for family coverage.

When will my Dependent become covered?
Coverage for a Dependent will take effect on the later of:
1. the date your coverage with us begins; or
2. the day you enroll your Dependent, if enrollment is requested within 31 days of the date the Dependent is acquired; or
3. the date specified in the Special Enrollments section; or
4. the date you acquire that new Dependent if the Eligible Person has family coverage at that time and no additional premium is required; or
5. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

The above provisions do not apply to newborn children, adopted children, children placed for adoption, and children for whom coverage is ordered by a court. Requirements for those children are

described in the following sections. In no event will coverage for a Dependent begin prior to the date your coverage begins.

Newborn Children.
Coverage for your newborn child will take effect on the later of:
1. the date your coverage begins with us; or
2. the moment of birth of the newborn. Coverage is provided for 31 days from the date of birth. In order to continue coverage beyond the 31 day period, you must enroll the child within 31 days of the date of birth and pay any required additional premium. Any required premium must be paid when due from the date of birth. If the enrollment and premium payment procedures are not followed, coverage will not continue beyond the 31 day period.

Adopted Children.
Coverage for a child adopted by you or for which a petition to adopt has been filed by you will take effect on the later of:
1. the date your coverage begins with us; or
2. the date of the filing of the petition for adoption if you apply for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and enrollment for coverage is filed within 60 days after the birth of the child.

Court Ordered Coverage.
If your child is enrolled as the result of a court order or administrative order, coverage for such child shall take effect on the date of enrollment once the required premium, if any, has been paid.

Dependent Status Change.
You must inform us or the Policyholder within 31 days of any Dependent change in family status.

Special Enrollments
If you decline coverage or decline coverage for your Dependents because of other coverage, you or your Dependents may enroll for coverage in the future during the special enrollment period described in paragraph A below.

In addition, if you acquire a new Dependent due to marriage, birth, adoption, placement for adoption **[**or new Domestic Partnership**]**, you and your Dependents may enroll for coverage during the special enrollment period described in paragraph B below.

A. Special Enrollment Period - Loss of other coverage:
   If you or your Dependents:
   4. failed to enroll when first eligible for coverage;
   5. lose other health coverage; and
   6. are otherwise eligible for coverage under the Policy,

   you or your Dependents may enroll for coverage under the Policy, but only if the following conditions are met:
   5. the person was covered under a health plan at the time coverage under the Policy was first offered to the person;
   6. the person stated in writing the reason for declining coverage was due to coverage under another health plan;
   7. If the other health coverage was:
      (a) COBRA continuation coverage, the COBRA continuation coverage has been exhausted for reasons other than failure to pay timely premiums or for cause; or

(b) other than COBRA continuation coverage, the coverage was either terminated due to loss of eligibility for coverage or the current or former employer terminated contributions towards the other coverage. Loss of eligibility for coverage includes a loss due to legal separation, **[**dissolution of Domestic Partnership,**]** divorce, death, termination of employment or reduction in the number of hours of employment. Loss of eligibility does not include loss due to failure to pay timely premiums or termination of coverage for cause; and

8. The person requests enrollment under the Policy not later than 30 days after the date the other coverage ended or the employer's contributions terminated.

Coverage under the Policy will become effective on the first day of the month following the date we receive the completed request for enrollment; or on an earlier date, as agreed to by us.

B. Special Enrollment Period - Change in Family Status

If you or your Dependents:

4. failed to enroll when first eligible for coverage;
5. are otherwise eligible for coverage under the Policy; and
6. you acquire a Dependent through marriage, **[**Domestic Partnership,**]** birth, adoption, or placement for adoption,

we will provide a special enrollment period for coverage as described below.

The special enrollment period is for 30 days and begins on the later of:

3. the date Dependent Coverage is made available under the Policy; or
4. the date of marriage or termination of marriage, **[**Domestic Partnership or termination of Domestic Partnership,**]** birth, adoption or placement for adoption.

During the special enrollment period, you may request enrollment for single coverage or family coverage for eligible Dependents who are not already enrolled under the Policy.

If enrollment is requested during this special enrollment period, coverage will be effective:

4. in the case of marriage **[**or Domestic Partnership**]**, on the first of the month following the date we receive the completed request for enrollment; or
5. in the case of a Dependent's birth, on the date of such birth; or
6. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

DEFINITIONS

Throughout this Certificate, when a term which has been capitalized, its meaning may be found in this section.

AGE
Age at last birthday.

APPLICATION
A form completed by Policyholder in applying for coverage under the Policy.

AWP
The average wholesale price of the Covered Drug, as set forth in the current price list in nationally recognized sources determined by Pharmacy Benefit Manager.

BENEFIT
The dollar amount payable by us to a Claimant under the Policy.

BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

CLAIMANT
A person making a claim under the Policy.

COMPOUND PRESCRIPTION
A prescription that meets the following criteria: two or more solid, semisolid, or liquid ingredients, at least one of which is a Covered Drug, that are weighed or measured then prepared according to the Prescriber's order and the Pharmacist's art.

CO-PAYMENT
The amount a Covered Person must pay for each Prescription or authorized refill. This amount, if any, is shown on the Plan Benefit Schedule in the Prescription Drug Benefits Provision and must be paid to the Provider at the time the services are received.

[COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

COVERED DRUGS
All FDA-approved, Legend Drugs including Generic Drugs, Brand-name Drugs, **[**and**]** Specialty Drugs**[**, Preferred Brand-name Drugs,**][** Non-Preferred Brand-name Drugs,**][** Covered Brand-name Drugs,**][** and**][** Non-Covered Brand-name Drugs**]** (except those listed in the General Exclusions and Limitations section of this Policy) that are prescribed by a Prescriber. The list of Covered Drugs is subject to periodic review and modification. The latest list of Covered Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

COVERED PERSON
You or your Dependent, who has enrolled for coverage and for whom premium has been paid to us, so long as coverage of such person under the Policy is in effect.

DEPENDENT
A person who may become covered or is entitled to benefits under the Policy and must be verified by the Policyholder if they are one of the following:
Your:
1. Spouse (if not legally separated or divorced from you).
2. **[**Domestic Partner.**]**
3. A child from the moment of birth, until the end of the calendar year that the child attains Age 19.
4. A child who is a student may be covered until the end of the calendar year that the child attains Age 25 provided such child is:
   (a) A Full-Time Student **[**or part-time student**]** or living in your household; and
   (b) More than 50% dependent on you for support and maintenance.
   (c) Proof of the child's enrollment as a student must be submitted to us.
5. Handicapped child who has attained either limiting Age shown above, if such child is:
   (a) Mentally retarded or physically incapable of earning their own living; and
   (b) Dependent on you for support and maintenance; and
   (c) Was covered on the day immediately prior to attaining the limiting Age.

Children include a stepchild, adopted child, a child under your charge, care and control whom you have filed a petition to adopt, or a child under the guardianship of you or your Spouse who are dependent upon you for support or a child for whom you are required to provide coverage by a court or administrative order. A foster child or a child who is a ward of the court is not considered to be a Dependent. A Dependent or Domestic Partner cannot also be enrolled as an Eligible Person under the Policy.

DISCOUNTED PRICE
The price that the Pharmacy Benefit Manager has negotiated for the medication, resulting in a price lower than AWP.

[DOMESTIC PARTNER
Two individuals who, together, each meet all of the following criteria set forth below:
1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the domestic partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
   (a) living together as a couple;
   (b) mutual support of each other;
   (c) mutual caring and commitment to each other;
   (d) mutual fidelity;
   (e) mutual responsibility for each other's welfare; and
   (f) joint responsibility for the necessities in life.
8. Have been living together as a couple for at least 6 months prior to obtaining the coverage provided under the Policy.

9. Intend to continue the domestic partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.**]**

ELIGIBLE CLASS
A description of Eligible Persons meeting all eligibility requirements in the Policy that is shown in the Application.

ELIGIBLE PERSON
You, whose employment or whose status with the Policyholder is the basis for eligibility for coverage under the Policy and who meets the enrollment rules. You cannot also be enrolled as a Dependent under the Policy.

EMPLOYEE
A person who is employed by**[**, or retired from and under Age 65 and not enrolled in Medicare**]** and paid by the Policyholder.

[ENROLLMENT PERIOD
The timeframe as defined by the Policy within which you may request coverage under the Policy. The following are the Enrollment Periods available to you under the Policy:
1. Initial enrollment period is a **[**30-90**]** day period after the effective date of the Policy when you may request enrollment for coverage under the Policy.
2. Annual Enrollment Period is the **[**month each calendar year**]** when you may request enrollment for coverage under the Policy.
3. Special Enrollment Period is a **[**30-90**]**-day period, based on qualifying events, when you may request enrollment for coverage under the Policy.**]**

FULL-TIME STUDENT
A person who is enrolled in and attending, on a full-time basis, a recognized course of study or training at: (1) an Accredited high school or vocational school; (2) an Accredited college or university; (3) a licensed technical or trade or similar training school, which offers general education classes. Full-Time Student status is determined by the standards set forth by the school, college or university. A person ceases to be a Full-Time Student at the end of the calendar month during which the person graduates or ceases to be enrolled and in attendance on a full-time basis. A person continues to be a Full-Time Student during periods of vacation established by the school, college, or university if he or she was a Full-Time Student on the day before the start of the vacation period. “Accredited” means the school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S. Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC. We may require proof of Full-Time Student status.

GENERIC DRUG
A multisource Generic Drug set forth in the Pharmacy Benefit Manager’s list of Generic Drugs, as reasonably determined by the Pharmacy Benefit Manager, and that is available in sufficient supply from multiple manufacturers. The list is subject to periodic review and modification. The latest list of Generic Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

LATE ENROLLEE
You or your Dependent who has declined coverage under a plan offered by the Policyholder at the time of the initial enrollment period provided under the terms of the plan, and who subsequently requests enrollment in a plan of that the Policyholder, provided that the initial enrollment period shall

be a period of at least **[**30-90**]** days. However, you or your Dependent shall not be considered a Late Enrollee if any of the conditions defined in the Special Enrollments Section are applicable.

LEGEND DRUGS
A drug that is required by federal or state law, to be dispensed pursuant to a prescription or order by an authorized Prescriber.

MAIL ORDER PHARMACY
The Pharmacy Benefit Manager's licensed mail order pharmacy subsidiaries, which provide prescription drugs via a mail order service.

[NON-COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Covered Brand-name Drug, refer to the latest list of Non-Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.**]**

[NON-PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Preferred Brand-name Drug, refer to the latest list of Non-Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.**]**

PARTICIPATING RETAIL PHARMACY
A retail pharmacy that has entered into an arrangement with the Pharmacy Benefit Manager that specifies the terms and conditions of the pharmacy's participation, including the rates that the Pharmacy Benefit Manager will pay the pharmacy.

PHARMACIST
An individual who is currently licensed in accordance with applicable law and regulations to engage in the practice of pharmacy.

PHARMACY
A site, properly licensed in accordance with applicable law and regulations, where drugs are dispensed or pharmaceutical care is provided by a licensed pharmacist.

PHARMACY BENEFIT MANAGER
The entity that administers and manages this generic prescription drug coverage program and, in connection therewith, has established networks of participating retail pharmacies and operates a system for the processing fulfillment and payment of claims for prescription drugs furnished by such pharmacies.

[PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.**]**

PRESCRIBER

A duly licensed health care practitioner who is authorized by law to write prescriptions or medication orders intended for the treatment or prevention of disease.

SPECIALTY DRUGS
Pharmaceutical products that are reasonably determined by the Pharmacy Benefit Manager to be biotechnological in nature and are used to treat certain conditions. The list is subject to periodic review and modification. The latest list of Specialty Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

SPOUSE
Your legal husband or wife as recognized by state law.

USUAL AND CUSTOMARY
The price that a Pharmacy charges a customer who does not have any form of prescription drug coverage.

[WAITING PERIOD
The period of time required by the Policyholder which must pass before coverage begins under the Policy for an Eligible Person.**]**

PRESCRIPTION DRUG BENEFITS PROVISION

The following Plan Benefit Schedule describes what the Covered Person will pay for Covered Drugs through the Pharmacy Benefit Manager or at a Participating Retail Pharmacy. Covered Drugs include all FDA-approved, Legend Drugs (except those listed in the General Exclusions and Limitations section) that are prescribed by a Prescriber.

Plan Benefit Schedule

[[Plan 1 – [Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 2 – [Super Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 0: **[**$0**]** Co-payment Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 0: **[**N/A**]** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 3 – [Value Generic with Preferred Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Preferred Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-3000**]** Individual / **[**$0-6000**]** Family**]** **[**Monthly Plan Maximum: **[**$0-250**]** Individual / **[**$0-500**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any

	Brand-name cost differential**]**
Specialty and Non-Preferred Brand-name Drugs	**[**100%**]** of a discounted amount

[[Plan 4 – [Value Generic with Managed Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Covered Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-3000**]** Individual / **[**$0-6000**]** Family**]** **[**Monthly Plan Maximum: **[**$0-250**]** Individual / **[**$0-500**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any Brand-name cost differential**]**
Specialty and Non-Covered Brand-name Drugs	**[**100%**]** of a discounted amount

The list of Generic, Brand-name and Specialty Drugs, and any additional drug and/or Tier, has been agreed to by the Policyholder, the Pharmacy Benefit Manager and us. The list is subject to periodic review and modification. The list can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

Participating Retail Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Mail-Order Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-

payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**

- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Filling a Prescription at a Participating Retail Pharmacy

In order to fill a prescription at a Participating Retail Pharmacy, the Covered Person will submit the Covered Person's prescription along with the Covered Person's prescription drug ID card to the Pharmacist at the Participating Retail Pharmacy. The Pharmacist will dispense the Covered Drug to the Covered Person and charge the Covered Person the appropriate amount.

Filling a Prescription at the Mail Order Pharmacy

In order to fill a prescription at the Mail Order Pharmacy, the Covered Person will fill-out a Mail Order Pharmacy order form and mail the completed form, the prescription, and the Covered Person's payment option to the Mail Order Pharmacy. In certain circumstances, the Covered Person may also have the Covered Person's Prescriber fax the Covered Person prescription to Mail Order Pharmacy. The Covered Person's prescription will be filled and the Covered Person will be charged the appropriate amount in accordance with the payment option the Covered Person has selected. Once filled, the prescription will be delivered to the Covered Person's home or office, by mail, usually within **[**10**]** days after Mail Order Pharmacy receives the Covered Person's initial prescription and **[**7**]** days after Mail Order Pharmacy receives the Covered Person's re-fill prescription. Mail Order Pharmacy will dispense Covered Drugs to the Covered Person in accordance with applicable law and regulations in the state in which Mail Order Pharmacy is located. Any prescriptions that are not dispensed will be returned to the Covered Person with an explanation as to why it could not be dispensed in accordance with Mail Order Pharmacy's standard operating procedures.

GENERAL EXCLUSIONS AND LIMITATIONS

We will not pay for:

1. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after 1 year from the Prescriber's original order.
2. Any quantity of medications dispensed for more than a **[**30-60**]**-day supply from a Participating Retail Pharmacy or **[**90-120**]**-day supply through the Pharmacy Benefit Manager.
3. Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the Covered Person.
4. Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
5. Federal and Non-Federal Legend Non-Drugs.
6. Charges for the administration or injection of any drug.
7. Substance abuse treatment.
8. Therapeutic devices and appliances.
9. Prescriptions for household pets.

[10. Medications not dispensed by a Participating Retail Pharmacy or the Pharmacy Benefit Manager.**]**

[11. The following drugs (both the Brand-name Drugs or Generic Drugs) are only available at the Brand-Name drugs pricing noted in the Plan Benefit Schedule section:

- Single source generic drugs i.e., those available from only a single manufacturer
- Impotence and erectile function medications
- Smoking deterrents (except Zyban®)
- Anti-obesity medications
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.**]**

[12. Isotretinoin products (Brand-name Drugs and Generic Drugs) including Accutane®, Amnesteem®, Sotret® and Claravis™.**]**

[13. Over-the-counter drugs and vitamins.**]**

[14. Ostomy supplies.**]**

[15. Non-systemic contraceptives, devices, implants, and injections.**]**

[16. Compound prescription drug products.**]**

[17. Topical fluoride products.**]**

[18. GlucoWatch®/GlucoWatch® Sensors.**]**

[19. Drugs labeled "Caution—limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.**]**

[20. Fertility Agents (except those Specialty Drugs which may be subject to the Generic Drug Benefits section).**]**

[21. Injectable Medications (except Brand-name Insulin & those which are Specialty Drugs subject to the Prescription Drug Benefits Provision).**]**

[22. Biologicals, Immunization Agents, Vaccines, Allergy Sera, Blood or Blood Plasma Products (except those Specialty Drugs which may be subject to the Prescription Drug Benefits Provision).**]**

[23. Other drugs as determined by us and the Pharmacy Benefits Manager. We will provide 60 days notice before adding a drug to this list of exclusions.**]**

Benefits are not provided for expenses which result directly or indirectly, wholly or partly from:

1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.
2. Declared or undeclared war or acts thereof.
3. Serving on full-time active duty in any armed forces of any country or international authority (any premium paid will be returned by us pro-rata for any period of active-full time duty).
4. Any Workers' Compensation Act, Occupational Disease law or similar law under which benefits were paid or received by the Covered Person.
5. The Covered Person operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
6. Charges for which:
   - there is no legal obligation to pay, or
   - no charge is made, or
   - in the absence of coverage, no charge would be made.
8. Charges incurred after coverage terminates under the Policy.
9. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
10. Charges for services which are not related to and consistent with the treatment of the Covered Person.

CLAIMS PROVISION

Direct Claim Process

The Covered Person will be able to submit a direct claim to the Pharmacy Benefit Manager in the event that the Covered Person pays the Usual and Customary price for the Covered Person's first purchase of a Generic Drug at a Participating Retail Pharmacy. For example, for the Covered Person's first purchase of Generic Drug, the Covered Person may forget to submit the Covered Person's prescription drug ID card to the Participating Retail Pharmacy, thus causing the Participating Retail Pharmacy to charge the Covered Person its Usual and Customary price for the Generic Drug (rather than the applicable Co-payment), In such event, the Covered Person may submit a direct claim to the Pharmacy Benefit Manager for reimbursement. The Covered Person may submit a direct claim by completing a direct claim form, with the receipt attached, and mailing it to Pharmacy Benefit Manager for processing and approval. Reimbursement will be based on the amount the benefit would have paid, less any applicable Co-payment.

Coordination of Benefits

There will be no Coordination of Benefits for allowed pharmacy charges between the Policy and another pharmacy/medical plan in which the Covered Person may be enrolled.

Notice of Claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to the Pharmacy Benefits Manager at their home office or to the Pharmacy Benefits Manager's agent. Notice should include the name of the Covered Person and the policy number.

Proof of Loss

If it is necessary to submit a direct claim form, it must be given to the Pharmacy Benefit Manager within 90 days of the claim. If it was not possible for the claim form to be given within 90 days, We will not deny the claim because of late filing, provided proof was given as soon as reasonably possible. In any case, the direct claim form must be sent no later than 1 year from the time specified, unless the Covered Person is legally incapacitated.

Payment Of Claims

Benefits payable under the Policy will be directly to: (a) the Covered Person or (b) the Covered Person's legally appointed guardian if the Covered Person is not legally able to accept such benefits. In the event the Covered Person dies we will pay any benefits due and not assigned to the Covered Person's estate. Any payment made in good faith fully discharges us to the extent of that payment.

Time of Payment of Claims

After receiving written proof of loss, we will pay monthly all benefits then due. Benefits for any other loss covered by the Policy will be paid as soon as we receive proper written proof.

PAYMENT OF PREMIUMS

Individual Premium Due Dates: The first premium for each Covered Person is due on the date the Covered Person becomes covered under the Policy. Each premium after the initial premium is due at the end of the period for which the Covered Person's preceding premium was paid.

Individual Grace Period: A grace period of 31 days from the Individual Premium Due Date is allowed for payment of each premium due after the initial premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, you will be liable to us for payment of any premium accruing during the period we continue coverage in force under this provision. The Grace Period will not continue beyond a date stated in a Termination provision.

Change of Policy Premiums: We have the right to change the premiums as follows:

1. on each Policy renewal date. We will give the Policyholder written notice of the change in premium rates at least **[**31 days**]** before the effective date of the change; and
2. on any date that the terms of the Policy are amended. We will give the Policyholder written notice of the change in Premium rates at least **[**31 days**]** before the effective date of the change**[**.**][**; and
3. on any date that the number of Covered Persons changes **[**by 10% or more**]**. We will give the Policyholder written notice of the change in premium rates.**]**

TERMINATION OF COVERAGE

Termination of Individual Coverage.
Coverage for a Covered Person shall automatically end on the earliest of the dates specified below:

1. the date the Policy is terminated;
2. the last day of the month in which you no longer meet eligibility requirements, unless an alternative date is otherwise stated in the Policy. You must notify us in writing within **[**30-60**]** days of a change, or termination of court or administrative ordered coverage;
3. the end of the period for which premium was last remitted for a Covered Person by the Policyholder if the Policyholder fails to remit premium when due;
4. the end of the period for which the last premium contribution is made, if premium contributions by you are required;
5. the date the Policyholder terminates the coverage for the Eligible Person's unit or class;
6. the last day of the month in which you are disabled, laid-off or on leave of absence.
7. the date you replace this coverage with another health benefit plan;
8. the date specified by us in written notice to the Covered Person that all coverage under the Policy will end because the person misused his or her identification card, including but not limited to permitting a person not authorized by us to use the Identification Card to obtain covered services.

In addition, coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder.

Dependent Coverage, if applicable, will cease on the earliest of the following dates:

1. the date you are no longer in a Eligible Class for Dependent coverage; or
2. the date you or the Policyholder cease premium payments for Dependent coverage; or
3. the date we cancel all Dependent coverage under the Policy; or
4. the date your coverage ceases.

In addition, Dependent’s coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked by you falls below the minimum required hours.

COBRA Coverage
A Covered Person whose coverage under the Policy would otherwise end may be entitled to elect continuation coverage under federal law or state law.

1. General Requirements:

   Continuation Coverage under COBRA applies only to employers which are subject to the provisions of COBRA. The Covered Person should contact the Policyholder's plan administrator to determine if the Covered Person is eligible to continue coverage under COBRA. We are not obligated to provide continuation Coverage to a Covered Person if the Policyholder or its designated plan administrator fails to perform its duties under federal law. These duties include but are not limited to:
   (a) notifying the Covered Person in a timely manner of the right to elect continuation coverage; and
   (b) notifying us in a timely manner of the Covered Person's election of continuation coverage.

   We are not the Policyholder's designated plan administrator and do not assume any duties of a plan administrator pursuant to federal law.

If the Covered Person chooses continuation coverage under a prior plan which was replaced by the Policy, the Covered Person's continued coverage shall terminate as scheduled under the prior plan or in accordance with the terminating events stated in item 4 below, whichever is earlier;

2. Qualifying events for COBRA Continuation Coverage:

   If the Covered Person's coverage terminates due to one of the following qualifying events, the Covered Person is entitled to continue coverage. The Covered Person may elect the same coverage that the Covered Person had at the time of the qualifying event. Qualifying events are:
   (a) Termination of the Eligible Person from employment with the Policyholder or reduction of hours, for any reason other than gross misconduct; or
   (b) Death of the Eligible Person; or
   (c) Divorce or legal separation from the Eligible Person; or
   (d) A Dependent child's loss of eligibility; or
   (e) Entitlement of the Eligible Person to Medicare benefits; or
   (f) For a retired Eligible Person and his or her Dependents, the filing of Chapter 11 bankruptcy by the Policyholder;

3. COBRA Notification Requirements and Election Period:

   The Covered Person must notify the Policyholder's designated plan administrator within 60 days of his or her divorce, legal separation or loss of eligibility as a Dependent.

   Continuation must be elected by the later of:
   (a) 60 days after the Covered Person's qualifying event occurs; or
   (b) 60 days after the Covered Person receives notice of the continuation right from the Policyholder's designated plan administrator.

   The Covered Person must pay the initial premium due to the Policyholder's designated plan administrator within 45 days after electing continuation. The Covered Person's monthly premium under COBRA may exceed the Group rate;

4. Terminating Events for COBRA Continuation Coverage:

   COBRA continuation under the Policy will end on the earliest of the following dates:
   (a) 18 months from the date continuation began, if the Covered Person's coverage ended because employment was terminated or hours were reduced. If a Covered Person is disabled at any time during the first 60 days of COBRA coverage, beginning on the day after termination of employment or reduction in hours, continuation coverage may be extended to a maximum of 29 months. Tthe Covered Person must give notice of the Covered Person's disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend coverage beyond 18 months. If the Covered Person provides such notice, the Covered Person's coverage may be extended up to a maximum of 29 months from the date of such qualifying event or until the first month that begins more than 30 days after the date of any final decision that the Covered Person is no longer disabled. If the disabled Covered Person has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29 month disability extension. A Covered Person must provide notice of any final determination that he or she is no longer disabled within 30 days of such determination;
   (b) 36 months from the date continuation began for a Dependent whose coverage ended because of the death of the Eligible Person, divorce or legal separation from the Eligible Person, loss of

eligibility by a Dependent child or entitlement of the Eligible Person to Medicare benefits, in accordance with qualifying events 2b through 2e above;

(c) The date coverage terminates under the Policy for failure to make timely payment of the premium;

(d) The date coverage is obtained under any other group health plan. If such coverage has a limitation or exclusion with respect to a Covered Person's pre-existing condition, continuation will end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health care except health care which is subject to the pre-existing condition limitation or exclusion. If the other group health plan's pre-existing condition limitations or exclusions cannot be applied because of the restrictions under the Health Insurance Portability and Accountability Act of 1996, then COBRA continuation will end on the date the Covered Person became covered under the other group health plan;

(e) The date the Covered Person becomes entitled to Medicare, except that this will not apply if the coverage was terminated because the Policyholder filed for bankruptcy, in accordance with qualifying event 2f of Section (2) above;

(f) The date the Policy terminates;

(g) The date coverage would otherwise terminate under the Policy.

If the Covered Person’s coverage ended because employment was terminated or hours reduced as described in item 2a above, and during the 18 month continuation period a second qualifying event occurs, coverage may be extended up to a maximum of 36 months. The 36 month period starts from the date coverage ended due to the first qualifying event. If the Covered Person is entitled to continuation because the Policyholder filed for bankruptcy, as described in item 2f above and the retired Eligible Person dies during the continuation period, the Dependents are entitled to continue coverage for 36 months from the date of death. Terminating events 4b through 4g shall apply during any extended continuation period.

A Dependent whose continuation coverage terminates because the Eligible Person becomes entitled to Medicare should contact the Policyholder's designated plan administrator for information regarding an extension of continuation Coverage for an additional period of time.

[Continuation coverage under COBRA is not available to Domestic Partners, if Domestic Partner coverage is available to the Covered Person.**]**

GENERAL PROVISIONS

Conformity with State Statutes. If any part of the Policy does not conform to a statute in the state in which it is issued or delivered, it is amended to conform with the minimum statutes of that state.

[ERISA. If the Policy is being purchased to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. Section 1001 et seq., We are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.**]**

Legal Actions. No action at law or in equity may begin prior to 60 days after we receive a valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

Workers' Compensation Not Affected. The Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

Important Notice. If you or any Covered Person has any questions or concerns about coverage under the Policy or if you or any Covered Person would like to make any comments or complaints, please call **[**1-800-XXX-XXXX**]**.

APPEAL OF PRESCRIPTION DRUG PROGRAM CLAIMS

The appeals process begins when you or the your representative submits a request for benefit coverage in writing. The Pharmacy Benefit Manager reviews this request and either approves or denies coverage in writing based on the plan's parameters (i.e., initial benefit determination). Written notification of pre-service requests is provided within 15 days. Written notification of post-service requests is provided within 30 days.

Level One Appeals Process

If a request results in a denial or reduction of coverage, you may appeal the decision in writing within 180 days after receiving notice of the initial claim decision. To start a level one appeal, You or Your authorized representative (such as your doctor) must provide, in writing, your name, member ID, phone number, the prescription drug for which a claim has been denied, and any additional information that may be related to your appeal.

Additional information for appeals should be mailed to:
[Appeals Administrator
Address
City, State Zip**]**

The additional information will be reviewed and evaluated by a dedicated appeals unit at the Pharmacy Benefit Manager to determine if the drug use meets coverage conditions specified or intended by the plan. If approval is granted, benefits are authorized for the proposed drug therapy. If a claim is denied, in whole or in part, the notice will refer to the specific plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your denied claim.

Level Two Appeals Process

If you are not satisfied with the initial appeal decision, you may request in writing, within 90 days after receiving notice of the appeal decision, a level two appeal. The level two appeals committee for administrative appeals consists of three professionals: a Pharmacist supervisor, a Pharmacist, and either an additional Pharmacist or a managed care representative or quality assurance specialist. No level two appeals committee member, nor his or her subordinates, will have been involved in either the original coverage decision or the level one appeal.

Expedited Appeals

You may request that the appeal process be expedited if the periods under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your doctor, would cause you severe pain which cannot be managed without the requested services. When an appeal is expedited, the Pharmacy Benefit Manager will respond orally with a decision within 72 hours, followed up in writing.

[STATEMENT OF EMPLOYEE RIGHTS UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the employee group prescription drug plan provided by the Plan Sponsor, (the "Plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. The Plan Administrator for your plan may be your benefits committee or benefits administrator, and is specified in the Plan's Summary Plan Description. Your Plan Administrator is not Nationwide Life Insurance Company. Your Certificate of Coverage is not the Plan's Summary Plan Description. ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other locations (worksites and union halls), all documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U. S. Department of Labor, such as annual reports and plan descriptions.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The Companies are not fiduciaries of the Plan.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court against the Plan. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court, if you have exhausted the remedies provided for review of Adverse Benefit Determinations. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.**]**

Stonebridge Life Insurance Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**

Prescription Drug Plan

EMPLOYER APPLICATION

Requested Effective Date: / /

Premium Deposit: $_____
Approximately 1 month's premium, payable to "Stonebridge Life Insurance Company"

Group Representative:

Plan Selected: **[**• Value Generic

Generic:	Participating Retail Pharmacy:	Tier 1 Company ____; ____day supply
Generic:	Participating Retail Pharmacy:	Tier 1 Company ____; ____day supply
Generic:	Mail Order:	Tier 1 Company ____; ____day supply
Generic:	Mail Order:	Tier 1 Company ____; ____day supply
Brand-Name:		____% of discounted amount;
Specialty:		____% of discounted amount**]**

Premium: **[**• Prescription Drug Coverage – Employee Only: $_____
• Prescription Drug Coverage – Employee + Child: $_____
• Prescription Drug Coverage – Employee + Spouse: $_____
• Prescription Drug Coverage – Employee + Family: $_____**]**

Application is hereby made for the Benefits set forth herein.
The information given below shall be the basis of the agreement with the Plan Sponsor.

Administrative Information

Legal Company Name				
Location Address	**City**	**State**	**Zip**	**County**
Mailing Address (if different than above)	**City**	**State**	**Zip**	
Phone ( ) -	**Administrative Contact**			
Fax ( ) -	**Title**			
Email Address	**Business Start Date**	**Employer's Tax Identification Number**		

List names and addresses of all affiliates, branches or subsidiaries on a separate sheet of paper and submit with this application.

Billing Arrangements: Are there multiple units/locations to be billed separately?

• No • Yes – number of units _____ • Bill to Individual Units • Bill to Plan Sponsor

Describe the Nature of Business	**SIC Code**

Number of Employees working [20] or more hours per week year-round _____
Number of Employees working fewer than [20] hours per week year-round _____
Number of Employees working other hours, seasonal, etc. _____ **(please describe)**
Please submit copy of most current Employer's Report of Wages and Employer's Contribution Report ("OBES" Report).
For any company owners not shown on the Employer's Report of Wages, submit other documentation showing earnings from this business, such as tax Form 1099 or Schedule (C, K-1, SE, etc.).

Are any of the employees noted above part of an Employee Leasing Firm or a Professional Employee Organization? • No • Yes

List the Names and Dates of Birth of all former Employees/Dependents on Continuation of Coverage or COBRA:
Include completed COBRA form for each

_____ _____
_____ _____
_____ _____
_____ _____

Will this policy be replacing an existing group Health Plan?	• No • Yes – Current Carrier:
Employer Contribution:	_____% of Premium Amount
Participation Requirements:	_____% of Employees

Eligible Classes Requested:

[• All employees
- All Employees
- All regular full-time Employees
- All Employees, except _____
- Dependent of Employees
- Other _____**]**

Waiting Period:

[• Waiting Period (current Employees): • Effective Date • 2 Months • Other _____
• 1 Month • 3 Months
• Waiting Period (new Employees): • 1 Month • 2 Months • Other _____
• 3 Months • Date Employed
New Employees are covered on the first day of the month following the Waiting Period**]**

Open Enrollment Period:

[• Dates_____ • Not Applicable

General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. Benefit Coverage shall not become effective unless this application is accepted and approved by the Stonebridge Life Insurance Company.
2. All benefits will be issued on a non-occupational basis unless otherwise indicated.
3. The prospective Plan Sponsor (or the administrator) will furnish and maintain records required to administer the benefit plan, will report changes prior to the effective date of a change in the group, and will make all premium payments according to the terms of the contract.
4. The employer will collect employee contributions through payroll deductions.
5. The prospective Plan Sponsor has received and reviewed a Stonebridge Life Insurance Company proposal, and understands the material facts contained in the proposal.
6. Coverage will be deferred until the annual enrollment period for any eligible employee considered a Late Enrollee. Special Enrollees are exempt from this deferral.

Do not cancel your current insurance plan until you have received written confirmation of acceptance by Stonebridge Life Insurance Company.

Stonebridge Life Insurance Company relies upon the accuracy of information included on the application and enrollment forms in determining the appropriate Premium rate for this Applicant. We reserve the right to retroactively adjust the Premium rate at any time in the event we determine that inaccurate information was provided to us upon which we relied in determining the premium rate. If the readjusted Premium is not paid, the Policy will be terminated. Failure to meet participation requirements will also result in an increase to the proposed rates or may result in termination with 45 days notice.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated At:
Dated On:

By: _____ _____ _____
Signature of Employer *Printed name of Employer* *Job Title*

Employer's signature witnessed by *(must be 18 or older)*:

_____ _____
Signature of Witness *Printed name of Witness*

SLRX2010GA.AR

Stonebridge Life Insurance Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**

Prescription Drug Plan

EMPLOYEE ENROLLMENT FORM

Employee Last Name	Suffix (e.g., Sr., Jr.)	First Name	M/I	E-mail Address	Home Phone
					( ) -

Residence Address	City	County	ST	Zip Code	Business Phone
					( ) -

Mailing Address if different than above:

Social Security Number	Date of Birth	Gender
- -	_____-_____-_____	• M • F

Employer Name	Job Title	Hours Worked	Earnings Reported on
		Per Week _____	• W2 • Other (Explain)_____

- Active Employee – List Full-Time Hire Date _____-_____-_____
- COBRA Coverage – List Qualifying Event Date _____-_____-_____ & Description

Section II – Election or Refusal of Coverage

Please check a box for each coverage.

Elect: **[**• Prescription Drug Coverage – Employee Only • Prescription Drug Coverage – Employee + Child • Prescription Drug Coverage – Employee + Spouse • Prescription Drug Coverage – Employee + Family**]**

Refuse: • Prescription Drug Coverage

If not electing coverage, is the reason you are refusing because you are currently covered by an employer-sponsored health plan?
• No • Yes If yes, please list the following: Employer Name Carrier Name Policy #

IF YOU ARE REFUSING COVERAGE, PLEASE READ THE IMPORTANT NOTICES IN SECTION IV, SIGN HERE AND STOP.
IF YOU ARE ELECTING COVERAGE, PLEASE COMPLETE ALL REMAINING SECTIONS.

_____ _____ _____-_____-_____
Employee Name (Print) Employee Signature Date

Section III – Enrollment Information

If your employer is offering dependent coverage, list all your dependents to be covered. (Use separate sheet if necessary.)

Relation	Name: Last, Suffix (e.g. Sr., Jr.) First, MI) 1	Social Security Number	Date of Birth2	Gender
Spouse		- -	- -	• M • F
Child		- -	- -	• M • F
Child		- -	- -	• M • F
Child		- -	- -	• M • F

1) For each spouse or child whose last name is different than the employee's last name, clearly indicate reason (e.g. employee or spouse kept maiden name; child from a previous marriage or relationship; other)_____
2) For each child over the age of 18 and a full-time student, submit documentation from the accredited school showing full-time status, such as current course schedule or grade report.

Section IV – Please Read the Following Important Notices

Late Enrollees If you are waiving/declining health coverage for yourself and/or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself and/or your dependents if the other health coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents for health coverage, if you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you waive/decline coverage for yourself and/or your dependents for any other reason, you may be considered a late enrollee and will only be permitted to enroll during the group's annual enrollment period, subject to the pre-existing conditions limitation.

Confirmation I agree that the information set forth on this enrollment form is correctly recorded, complete and true to the best of my knowledge and belief, and that it forms the basis of my insurance. I further agree that the Certificate together with this Enrollment Form, the Policy, and Policyholder's Application, and any amendments or riders will completely describe the benefits and conditions of the insurance agreement. Stonebridge Life Insurance Company (hereafter referred to as "Company") will rely and act upon the answers

and information I provide on this Enrollment Form. The Company reserves the right to retroactively adjust the premium rate for the group at any time in the event of a material misrepresentation of information has occurred. My insurance coverage will not become effective until this Enrollment Form is received and approved by the Company, and in no event prior to the effective date of the Policy issued to my employer.
Your coverage is subject to an agreement with Participating Retail Pharmacies. It is important that you verify that your pharmacy is a participating pharmacy each time you make a purchase.

Section V – Please [Read,]Sign and Date (in ink) Below

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____	_____	_____-_____-_____
Name of Employee (Print)	Employee Signature (In ink)	Date

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/17/2009

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/17/2009

Comments:

Application and Enrollment Form attached to Forms Schedule Tab

		Item Status:	Status Date:
Satisfied - Item:	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	12/17/2009

Comments:

Attachment:

AR - NAIC TRANSMITTAL DOCUMENT.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Stonebridge Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
SLRX2010GP	43.09
SLRX2010GC	44.24
SLRX2010GA	45.01
SLRX2010GE	44.22

Signed: _____

Name: Edward G. Weigand

Title: Assistant Secretary

Date: 12/14/2009

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Stonebridge Life Insurance Company 29 South Main Street Rutland VT 05701-5014		VT		468	65021	03-0164230	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Edward G. Weigand 520 Park Avenue Baltimore MD 21201		800-233-4624 Ext. 5265	410-209-5910	eweigand@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	GH AR0052015F01
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☐ Individual ☐ Franchise Group: ☐ Small ☒ Large ☐ Small and Large ☒ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H17G Group Health - Prescription Drug
10.	**Product Coding Matrix Filing Code**	H17G.000 Health - Prescription Drug
11.	**Submitted Documents**	☒ **FORMS** ☒ Policy ☐ Outline of Coverage ☒ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☒ Statement of Variability ☐ Certifications ☒ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	12/14/2009
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	Pending
15.	**Filing Description:**	

NAIC #468-65021
Forms Filing

RE: SLRX2010GP - Prescription Drug Program

Forms including in Filing:
Group Prescription Drug Program
SLRX2010GP - Group Policy
SLRX2010GC - Certificate
SLRX2010GA - Group Application
SLRX2010GE - Enrollment Form

The enclosed forms are being submitted for your review and approval. These forms are new and in compliance with the insurance laws and rules of your sate.

Group Policy Form SLRX2010GP provides coverage for prescription drug expenses. The product will be issued to employer groups.

These forms are being filed concurrently in our domicile state of Iowa.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Sincerely

Edward G. Weigand
Director
410-209-5265
eweigand@aegonusa.com

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Edward G. Weigand Title Director, Product Filing & Compliance and Licensing

Signature  Date 12/14/2009

SERFF Tracking Number:	*AEGX-126418328*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44327*
Company Tracking Number:	*GH AR0052015F01*		
TOI:	*H17G Group Health - Prescription Drug*	*Sub-TOI:*	*H17G.000 Health - Prescription Drug*
Product Name:	*Prescription Drug*		
Project Name/Number:	*Prescription Drug/GH AR0052015F01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/14/2009	Form	Group Prescription Drug Coverage Policy	12/17/2009	SLRX2010GP.PDF (Superceded)
12/14/2009	Form	Group Prescription Drug Coverage Certificate	12/17/2009	SLRX2010GC.PDF (Superceded)
12/14/2009	Form	Group Application	12/17/2009	SLRX2010GA.PDF (Superceded)
12/14/2009	Form	Enrollment Form	12/17/2009	SLRX2010GE.PDF (Superceded)

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**
(Hereafter called we, us or our)

Policyholder:	**[ABC Employer]**
Policy Number:	**[A12345]**
Effective Date:	**[01/01/2010]**
First Policy Anniversary:	**[01/01/2011]**
Subsequent Policy Anniversaries:	**[01/01 each subsequent year thereafter]**
State or Other Jurisdiction of Issue:	**[State]**

We agree to insure the eligible persons described in this Policy. We will do this while this Policy stays in force. We agree to pay the benefits of this Policy to the persons insured. Details of the benefits are shown in this Policy.

The Policyholder has applied for this Policy and understands that the required premium must be paid to get the insurance and keep it in force.

When This Policy Will Take Effect
This Policy will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date above, its date of issue.

IN WITNESS WHEREOF, we have signed this policy at Rutland, Vermont.

Craig D. Vermette
Secretary

Marilyn Carp
President

TABLE OF CONTENTS

GROUP PRESCRIPTION DRUG COVERAGE POLICY

THIS POLICY PROVIDES LIMITED COVERAGE. READ IT CAREFULLY.
Non-Participating

INTRODUCTION

In consideration of the premium payments in the amounts and at the times provided, we agree to underwrite the coverage subject to the terms and conditions set forth in this Policy which includes the Group Application attached to this Policy, and fully incorporated herein by reference.

The entire contract includes this Policy, and the Application, any amendments, any riders, and any attachments, together with the Enrollment Forms.

We consider any statement made by a Covered Person or the Policyholder, in the absence of fraud, to be a representation and not a warranty. No statement will be used to avoid the insurance, reduce benefits, or deny a claim unless: the statement is signed and in writing; and a copy of that statement is given to the Covered Person or Beneficiary.

This Policy may be changed at any time by a written agreement between the Policyholder and us. Only our executive officers can change this Policy. The agent does not have the authority to make a promise or statement that binds us. The agent may not accept any late premiums or extend the due date of any premium.

ELIGIBILITY AND EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Eligible Person

An Eligible Person who has met all eligibility requirements of the Policyholder prior to the Effective Date of this Policy may request enrollment during the enrollment period that precedes the Effective Date of this Policy. An Eligible Person who does not enroll during this period will be considered a Late Enrollee. This enrollment period is determined between us and the Policyholder.

After the Effective Date of this Policy, an Eligible Person who does not request enrollment during the following time periods or during a special enrollment period will be considered a Late Enrollee:

1. if this Policy has a Waiting Period, enrollment must be requested no later than **[**30-60**]** days after the end of the Waiting Period;
2. if this Policy does not have a Waiting Period, enrollment must be requested no later than **[**30-60**]** days after the date of hire.

Enrollment is made by completing the enrollment process, as specified. An Eligible Person may enroll for **[**single, Eligible Person and Spouse, Eligible Person and Dependent, or Eligible Person and family. "Single" covers the Eligible Person only. "Family" covers the Eligible Person, Spouse, and his or her eligible Dependents.**]** An Eligible Person cannot also enroll as a Dependent under this Policy.

A person is eligible if the person is included in an Eligible Class listed in the Application and the person is:

1. performing all the normal duties of the persons job at the normal place of business of the Policyholder;
2. working in an Eligible Class shown in the Application;
3. working the minimum required hours at the normal place of business of the Policyholder;
4. **[**if the person is retired from the Policyholder, under age 65 and not enrolled in Medicare; and**]**
5. the person does not have an insurance plan that provides drug benefits.

A person shall cease to be an Eligible Person on the first day of the month following any month in which the number of hours worked falls below the minimum required hours **[**or the Eligible Person reaches age 65 and becomes enrolled in Medicare**]**.

Eligible Dependent

If this Policy provides for family coverage, an Eligible Person may request enrollment of his or her Dependents:

1. at the time the Eligible Person requests enrollment for himself or herself; or
2. when the Eligible Person acquires a new Dependent; or
3. during a special enrollment period.

Proof of the Dependent relationship may be required by us. A Dependent that is not enrolled as described above will be considered a Late Enrollee. A Dependent cannot be enrolled prior to the date the Eligible Person has enrolled for coverage under this Policy.

A person may be enrolled as a Dependent if he or she is:

1. the Eligible Person's Spouse; or
2. the Eligible Person's Dependent child.
3. **[**the Eligible Person’s Dependent Domestic Partner and the children of the Domestic Partner. A person may be enrolled as a Domestic Partner, or the Domestic Partner’s children may be enrolled, if he or she provides us with a copy of a valid Declaration of Domestic Partnership that has been filed with the Secretary of State or has filed an Affidavit of Domestic Partnership with us

and is meeting the requirements set forth by us for Domestic Partnership coverage and meets the definition of Dependent as defined**]**.

If a court or administrative order requires the Eligible Person to provide health care coverage for his or her child and this Policy provides for family coverage, we will:
1. Allow the Eligible Person to enroll such child under family coverage if the child is otherwise eligible and not apply any enrollment period restrictions; or
2. Allow the child's other parent to enroll the child if the Eligible Person fails to enroll the child for family coverage.

Dependents are eligible if:
1. the Eligible Person is in a class that qualifies for Dependent benefits; and
2. the Eligible Person makes a written request giving any information we may require; and
3. the Dependent is not in an Eligible Class.

A person may not be covered more than once under this Policy at the same time. If both husband and wife are covered under this Policy, either, but not both, may elect to cover their eligible Dependent children.

Effective Date of Individual Coverage – Eligible Person
Coverage for an Eligible Person will take effect on the later of:
1. the Effective Date of this Policy; or
2. the **[**first day of the month that next follows the**]** date he or she completes the Waiting Period, if any, as long as enrollment is requested within 31 days after the end of the Waiting Period. If the Waiting Period ends on the first day of the month, coverage will begin on that day, if he or she enrolls during the Waiting Period; or
3. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

The Eligible Person must complete the enrollment process. If the Eligible Person is required to pay all or part of the premium for coverage, the Eligible Person must acknowledge the Eligible Person's permission to the Policyholder to withhold such premium from the Eligible Person's pay.

[Waiting Period
The Waiting Period for an Eligible Person who is not a Late Enrollee is **[**30-60**]** days. The Waiting Period will begin **[**on the employee's date of hire or the date the employee qualifies as an Eligible Person**]**. A Late Enrollee can only enroll during the Policyholder's annual enrollment period, which is held once each calendar year and is held open for **[**30-90**]** consecutive days.**]**

Effective Date of Individual Coverage – Eligible Dependent
Coverage for a Dependent will take effect on the later of:
1. the date the Eligible Person's coverage with us begins; or
2. the day the Eligible Person enrolls his or her Dependent, if enrollment is requested within 31 days of the date the Dependent is acquired; or
3. the date specified in the Special Enrollments section; or
4. the date the Eligible Person acquires that new Dependent if the Eligible Person has family coverage at that time and no additional premium is required; or
5. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

The above provisions do not apply to newborn children, adopted children, children placed for adoption, and children for whom coverage is ordered by a court. Requirements for those children are

described in the following sections. In no event will coverage for a Dependent begin prior to the date coverage begins for the Eligible Person.

Newborn and Adopted Children/Children Placed for Adoption.
Coverage for the newborn child of an Eligible Person or Spouse, or a child adopted by or placed for adoption with an Eligible Person will take effect on the later of:

1. the date coverage for the Eligible Person begins with us; or
2. the moment of birth of the newborn or the date of adoption or date of placement of the child. Coverage is provided for 31 days from the date of birth, adoption or placement. In order to continue coverage beyond the 31 day period, the Eligible Person must enroll the child within 31 days of the date of birth, adoption or Placement and pay any required additional premium. Any required premium must be paid when due from the date of birth, adoption or placement. If the enrollment and premium payment procedures are not followed, coverage will not continue beyond the 31 day period.

Date of Placement means the date of assumption and retention by an Eligible Person of a legal obligation for total or partial support of a child to be adopted.

Court Ordered Coverage.
If a child of the Eligible Person is enrolled as the result of a court order or administrative order, coverage for such child shall take effect on the date of enrollment once the required premium, if any, has been paid.

Dependent Status Change.
The Eligible Person must inform us or the Policyholder within 31 days of any Dependent change in family status.

Dependent Enrollment
The Eligible Person must complete the enrollment process which includes giving the information we require for all Dependents and authorizing the Policyholder to make payroll deductions toward the cost of Dependent's coverage (if applicable). This enrollment process must be completed prior to the expected birth of a child. The Eligible Persons must then notify us upon the birth of a child. If the Eligible Person did not elect Dependent's coverage before the birth of a child, coverage on that child will not be denied, if we are notified in writing of the birth of such child and the Policyholder is authorized to make the required payroll deductions toward the cost of Dependent's coverage, within 31 days of the date of birth. If Dependent coverage is already available for one Dependent, more Dependents later acquired will be added as of the date such Dependent is acquired. However, we require notification of additional Dependents to assure accurate claims handling and billing.

Special Enrollments
If an Eligible Person declines coverage or declines coverage for his or her Dependents because of other coverage, the Eligible Person or the Dependents may enroll for coverage in the future during the special enrollment period described in paragraph A below.

In addition, if the Eligible Person acquires a new Dependent due to marriage, birth, adoption, placement for adoption **[**or new Domestic Partnership**]**, the Eligible Person and Dependents may enroll for coverage during the special enrollment period described in paragraph B below.

A. Special Enrollment Period - Loss of other coverage:
   If an Eligible Person or his or her Dependents:
   1. failed to enroll when first eligible for coverage;
   2. lose other health coverage; and

3. are otherwise eligible for coverage under this Policy,

the Eligible Person or Dependents may enroll for coverage under this Policy, but only if the following conditions are met:

1. the person was covered under a health plan at the time coverage under this Policy was first offered to the person;
2. the person stated in writing the reason for declining coverage was due to coverage under another health plan;
3. If the other health coverage was:
   (a) COBRA continuation coverage, the COBRA continuation coverage has been exhausted for reasons other than failure to pay timely premiums or for cause; or
   (b) other than COBRA continuation coverage, the coverage was either terminated due to loss of eligibility for coverage or the current or former employer terminated contributions towards the other coverage. Loss of eligibility for coverage includes a loss due to legal separation, **[**dissolution of Domestic Partnership,**]** divorce, death, termination of employment or reduction in the number of hours of employment. Loss of eligibility does not include loss due to failure to pay timely premiums or termination of coverage for cause; and
4. The person requests enrollment under this Policy not later than 30 days after the date the other coverage ended or the employer's contributions terminated.

Coverage under this Policy will become effective on the first day of the month following the date we receive the completed request for enrollment; or on an earlier date, as agreed to by us.

B. Special Enrollment Period - Change in Family Status

If an Eligible Person or his or her Dependents:

1. failed to enroll when first eligible for coverage;
2. are otherwise eligible for coverage under this Policy; and
3. the Eligible Person acquires a Dependent through marriage, **[**Domestic Partnership,**]** birth, adoption, or placement for adoption,

We will provide a special enrollment period for coverage as described below.

The special enrollment period is for 30 days and begins on the later of:

1. the date Dependent Coverage is made available under this Policy; or
2. the date of marriage or termination of marriage, **[**Domestic Partnership or termination of Domestic Partnership,**]** birth, adoption or placement for adoption.

During the special enrollment period, the Eligible Person may request enrollment for single coverage or family coverage for eligible Dependents who are not already enrolled under this Policy.

If enrollment is requested during this special enrollment period, coverage will be effective:

1. in the case of marriage **[**or Domestic Partnership**]**, on the first of the month following the date we receive the completed request for enrollment; or
2. in the case of a Dependent's birth, on the date of such birth; or
3. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Reinstatement after Release from Active Duty

If coverage ends due to a Covered Person being called or ordered to active duty as a reservist, such coverage will be reinstated without any Waiting Period when the employee returns to Eligible Person status or when the Dependent is no longer on active duty.

Reinstatement after Termination of Employment

If coverage ends due to termination of employment and the employee later becomes employed by the Policyholder, he or she must meet all requirements of a new employee before coverage will become effective.

DEFINITIONS

Throughout this Policy, when a term which has been capitalized, its meaning may be found in this section.

AGE
Age at last birthday.

APPLICATION
A form completed by Policyholder in applying for coverage under this Policy.

AWP
The average wholesale price of the Covered Drug, as set forth in the current price list in nationally recognized sources determined by Pharmacy Benefit Manager.

BENEFIT
The dollar amount payable by us to a Claimant under this Policy.

BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

CLAIMANT
A person making a claim under this Policy.

COMPOUND PRESCRIPTION
A prescription that meets the following criteria: two or more solid, semisolid, or liquid ingredients, at least one of which is a Covered Drug, that are weighed or measured then prepared according to the Prescriber's order and the Pharmacist's art.

CO-PAYMENT
The amount a Covered Person must pay for each Prescription or authorized refill. This amount, if any, is shown on the Plan Benefit Schedule in the Prescription Drug Benefits Provision and must be paid to the Provider at the time the services are received.

[COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

COVERED DRUGS
All FDA-approved, Legend Drugs including Generic Drugs, Brand-name Drugs, **[**and**]** Specialty Drugs**[**, Preferred Brand-name Drugs,**][** Non-Preferred Brand-name Drugs,**][** Covered Brand-name Drugs,**][** and**][** Non-Covered Brand-name Drugs**]** (except those listed in the General Exclusions and Limitations section of this Policy) that are prescribed by a Prescriber. The list of Covered Drugs is subject to periodic review and modification. The latest list of Covered Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

COVERED PERSON
An Eligible Person or a Dependent of the Eligible Person, who has enrolled for coverage and for whom premium has been paid to us, so long as coverage of such person under this Policy is in effect.

DEPENDENT
A person who may become covered or is entitled to benefits under this Policy and must be verified by the Policyholder if they are one of the following:
An Eligible Person's:
1. Spouse (if not legally separated or divorced from the Eligible Person).
2. **[**Domestic Partner.**]**
3. A child from the moment of birth, until the end of the calendar year that the child attains Age 19.
4. A child who is a student may be covered until the end of the calendar year that the child attains Age 25 provided such child is:
   (a) A Full-Time Student **[**or part-time student**]** or living in the Eligible Person's household; and
   (b) More than 50% dependent on the Eligible Person for support and maintenance.
   (c) Proof of the child's enrollment as a student must be submitted to us.
5. Handicapped child who has attained either limiting Age shown above, if such child is:
   (a) Mentally retarded or physically incapable of earning their own living; and
   (b) Dependent on the Eligible Person for support and maintenance; and
   (c) Was covered on the day immediately prior to attaining the limiting Age.

Proof of incapacity must be furnished to us within 31 days of attainment of the limiting Age or qualifying event.

Children include a stepchild, adopted child, a child placed for adoption, or a child under the guardianship of the Eligible Person or the Eligible Person's Spouse who are dependent upon the Eligible Person for support or a child for whom the Eligible Person is required to provide coverage by a court or administrative order. A foster child or a child who is a ward of the court is not considered to be a Dependent. A Dependent or Domestic Partner cannot also be enrolled as an Eligible Person under this Policy.

DISCOUNTED PRICE
The price that the Pharmacy Benefit Manager has negotiated for the medication, resulting in a price lower than AWP.

[DOMESTIC PARTNER
Two individuals who, together, each meet all of the following criteria set forth below:
1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the domestic partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
   (a) living together as a couple;
   (b) mutual support of each other;
   (c) mutual caring and commitment to each other;
   (d) mutual fidelity;
   (e) mutual responsibility for each other's welfare; and
   (f) joint responsibility for the necessities in life.

8. Have been living together as a couple for at least 6 months prior to obtaining the coverage provided under this Policy.
9. Intend to continue the domestic partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.**]**

ELIGIBLE CLASS
A description of Eligible Persons meeting all eligibility requirements in this Policy that is shown in the Application.

ELIGIBLE PERSON
An Eligible Person or a person whose employment or whose status with the Policyholder is the basis for eligibility for coverage under this Policy and who meets the enrollment rules. An Eligible Person cannot also be enrolled as a Dependent under this Policy.

EMPLOYEE
A person who is employed by**[**, or retired from and under Age 65 and not enrolled in Medicare**]** and paid by the Policyholder.

[ENROLLMENT PERIOD
The timeframe as defined by this Policy within which an Eligible Person may request coverage under this Policy. The following are the Enrollment Periods available to an Eligible Person under this Policy:
1. Initial enrollment period is a **[**30-90**]** day period after the effective date of this Policy when an Eligible Person may request enrollment for coverage under this Policy.
2. Annual Enrollment Period is the **[**month each calendar year**]** when an Eligible Person may request enrollment for coverage under this Policy.
3. Special Enrollment Period is a **[**30-90**]**-day period, based on qualifying events, when an Eligible Person may request enrollment for coverage under this Policy.**]**

FULL-TIME STUDENT
A person who is enrolled in and attending, on a full-time basis, a recognized course of study or training at: (1) an Accredited high school or vocational school; (2) an Accredited college or university; (3) a licensed technical or trade or similar training school, which offers general education classes. Full-Time Student status is determined by the standards set forth by the school, college or university. A person ceases to be a Full-Time Student at the end of the calendar month during which the person graduates or ceases to be enrolled and in attendance on a full-time basis. A person continues to be a Full-Time Student during periods of vacation established by the school, college, or university if he or she was a Full-Time Student on the day before the start of the vacation period. “Accredited” means the school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S. Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC. We may require proof of Full-Time Student status.

GENERIC DRUG
A multisource Generic Drug set forth in the Pharmacy Benefit Manager’s list of Generic Drugs, as reasonably determined by the Pharmacy Benefit Manager, and that is available in sufficient supply from multiple manufacturers. The list is subject to periodic review and modification. The latest list of Generic Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

LATE ENROLLEE
An Eligible Person or Dependent who has declined coverage under a plan offered by the Policyholder at the time of the initial enrollment period provided under the terms of the plan, and who subsequently

requests enrollment in a plan of that the Policyholder, provided that the initial enrollment period shall be a period of at least **[**30-90**]** days. However, an Eligible Person or Dependent shall not be considered a Late Enrollee if any of the conditions defined in the Special Enrollments Section are applicable.

LEGEND DRUGS
A drug that is required by federal or state law, to be dispensed pursuant to a prescription or order by an authorized Prescriber.

MAIL ORDER PHARMACY
The Pharmacy Benefit Manager's licensed mail order pharmacy subsidiaries, which provide prescription drugs via a mail order service.

[NON-COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Covered Brand-name Drug, refer to the latest list of Non-Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

[NON-PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Preferred Brand-name Drug, refer to the latest list of Non-Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

PARTICIPATING RETAIL PHARMACY
A retail pharmacy that has entered into an arrangement with the Pharmacy Benefit Manager that specifies the terms and conditions of the pharmacy's participation, including the rates that the Pharmacy Benefit Manager will pay the pharmacy.

PHARMACIST
An individual who is currently licensed in accordance with applicable law and regulations to engage in the practice of pharmacy.

PHARMACY
A site, properly licensed in accordance with applicable law and regulations, where drugs are dispensed or pharmaceutical care is provided by a licensed pharmacist.

PHARMACY BENEFIT MANAGER
The entity that administers and manages this generic prescription drug coverage program and, in connection therewith, has established networks of participating retail pharmacies and operates a system for the processing fulfillment and payment of claims for prescription drugs furnished by such pharmacies.

[PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

PRESCRIBER
A duly licensed health care practitioner who is authorized by law to write prescriptions or medication orders intended for the treatment or prevention of disease.

SPECIALTY DRUGS
Pharmaceutical products that are reasonably determined by the Pharmacy Benefit Manager to be biotechnological in nature and are used to treat certain conditions. The list is subject to periodic review and modification. The latest list of Specialty Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

SPOUSE
The legal husband or wife of the Eligible Person as recognized by state law.

USUAL AND CUSTOMARY
The price that a Pharmacy charges a customer who does not have any form of prescription drug coverage.

[WAITING PERIOD
The period of time required by the Policyholder which must pass before coverage begins under this Policy for an Eligible Person.**]**

PRESCRIPTION DRUG BENEFITS PROVISION

The following Plan Benefit Schedule**[**s**]** describe**[**s**]** what the Covered Person will pay for Covered Drugs through the Pharmacy Benefit Manager or at a Participating Retail Pharmacy. Covered Drugs include all FDA-approved, Legend Drugs (except those listed in the General Exclusions and Limitations section) that are prescribed by a Prescriber.

Plan Benefit Schedule[s]

[[Plan 1 – [Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 2 – [Super Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 0: **[**$0**]** Co-payment Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 0: **[**N/A**]** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 3 – [Value Generic with Preferred Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Preferred Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Monthly Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any

	Brand-name cost differential**]**
Specialty and Non-Preferred Brand-name Drugs	**[**100%**]** of a discounted amount

[[Plan 4 – [Value Generic with Managed Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Covered Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Monthly Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any Brand-name cost differential**]**
Specialty and Non-Covered Brand-name Drugs	**[**100%**]** of a discounted amount

The list of Generic, Brand-name and Specialty Drugs, and any additional drug and/or Tier, has been agreed to by the Policyholder, the Pharmacy Benefit Manager and us. The list is subject to periodic review and modification. The list can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

Participating Retail Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Mail-Order Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-

payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**

- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Filling a Prescription at a Participating Retail Pharmacy

In order to fill a prescription at a Participating Retail Pharmacy, the Covered Person will submit the Covered Person's prescription along with the Covered Person's prescription drug ID card to the Pharmacist at the Participating Retail Pharmacy. The Pharmacist will dispense the Covered Drug to the Covered Person and charge the Covered Person the appropriate amount.

Filling a Prescription at the Mail Order Pharmacy

In order to fill a prescription at the Mail Order Pharmacy, the Covered Person will fill-out a Mail Order Pharmacy order form and mail the completed form, the prescription, and the Covered Person's payment option to the Mail Order Pharmacy. In certain circumstances, the Covered Person may also have the Covered Person's Prescriber fax the Covered Person prescription to Mail Order Pharmacy. The Covered Person's prescription will be filled and the Covered Person will be charged the appropriate amount in accordance with the payment option the Covered Person has selected. Once filled, the prescription will be delivered to the Covered Person's home or office, by mail, usually within **[**10-25**]** days after Mail Order Pharmacy receives the Covered Person's initial prescription and **[**7-15**]** days after Mail Order Pharmacy receives the Covered Person's re-fill prescription. Mail Order Pharmacy will dispense Covered Drugs to the Covered Person in accordance with applicable law and regulations in the state in which Mail Order Pharmacy is located. Any prescriptions that are not dispensed will be returned to the Covered Person with an explanation as to why it could not be dispensed in accordance with Mail Order Pharmacy's standard operating procedures.

GENERAL EXCLUSIONS AND LIMITATIONS

We will not pay for:

1. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after 1 year from the Prescriber's original order.
2. Any quantity of medications dispensed for more than a **[**30-60**]**-day supply from a Participating Retail Pharmacy or **[**90-120**]**-day supply through the Pharmacy Benefit Manager.
3. Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the Covered Person.
4. Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
5. Federal and Non-Federal Legend Non-Drugs.
6. Charges for the administration or injection of any drug.
7. Substance abuse treatment.
8. Therapeutic devices and appliances.
9. Prescriptions for household pets.

[10. Medications not dispensed by a Participating Retail Pharmacy or the Pharmacy Benefit Manager.**]**

[11. The following drugs (both the Brand-name Drugs or Generic Drugs) are only available at the Brand-Name drugs pricing noted in the Plan Benefit Schedule section:

- Single source generic drugs i.e., those available from only a single manufacturer
- Impotence and erectile function medications
- Smoking deterrents (except Zyban®)
- Anti-obesity medications
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.**]**

[12. Isotretinoin products (Brand-name Drugs and Generic Drugs) including Accutane®, Amnesteem®, Sotret® and Claravis™.**]**

[13. Over-the-counter drugs and vitamins.**]**

[14. Ostomy supplies.**]**

[15. Non-systemic contraceptives, devices, implants, and injections.**]**

[16. Compound prescription drug products.**]**

[17. Topical fluoride products.**]**

[18. GlucoWatch®/GlucoWatch® Sensors.**]**

[19. Drugs labeled "Caution—limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.**]**

[20. Fertility Agents (except those Specialty Drugs which may be subject to the Generic Drug Benefits section).**]**

[21. Injectable Medications (except Brand-name Insulin & those which are Specialty Drugs subject to the Prescription Drug Benefits Provision).**]**

[22. Biologicals, Immunization Agents, Vaccines, Allergy Sera, Blood or Blood Plasma Products (except those Specialty Drugs which may be subject to the Prescription Drug Benefits Provision).**]**

[23. Other drugs as determined by us and the Pharmacy Benefits Manager. We will provide 60 days notice before adding a drug to this list of exclusions.**]**

Benefits are not provided for expenses which result directly or indirectly, wholly or partly from:

1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.
2. Declared or undeclared war or acts thereof.
3. Serving on full-time active duty in any armed forces of any country or international authority (any premium paid will be returned by us pro-rata for any period of active-full time duty).
4. Any Workers' Compensation Act, Occupational Disease law or similar law under which benefits were paid or received by the Covered Person.
5. The Covered Person operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
6. Charges for which:
   - there is no legal obligation to pay, or
   - no charge is made, or
   - in the absence of coverage, no charge would be made.
8. Charges incurred after coverage terminates under this Policy.
9. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
10. Charges for services which are not related to and consistent with the treatment of the Covered Person.

CLAIMS PROVISION

Direct Claim Process

The Covered Person will be able to submit a direct claim to the Pharmacy Benefit Manager in the event that the Covered Person pays the Usual and Customary price for the Covered Person's first purchase of a Generic Drug at a Participating Retail Pharmacy. For example, for the Covered Person's first purchase of Generic Drug, the Covered Person may forget to submit the Covered Person's prescription drug ID card to the Participating Retail Pharmacy, thus causing the Participating Retail Pharmacy to charge the Covered Person its Usual and Customary price for the Generic Drug (rather than the applicable Co-payment), In such event, the Covered Person may submit a direct claim to the Pharmacy Benefit Manager for reimbursement. The Covered Person may submit a direct claim by completing a direct claim form, with the receipt attached, and mailing it to Pharmacy Benefit Manager for processing and approval. Reimbursement will be based on the amount the benefit would have paid, less any applicable Co-payment.

Coordination of Benefits

There will be no Coordination of Benefits for allowed pharmacy charges between this Policy and another pharmacy/medical plan in which the Covered Person may be enrolled.

Notice of Claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to the Pharmacy Benefits Manager at their home office or to the Pharmacy Benefits Manager's agent. Notice should include the name of the Covered Person and the policy number.

Proof of Loss

If it is necessary to submit a direct claim form, it must be given to the Pharmacy Benefit Manager within 90 days of the claim. If it was not possible for the claim form to be given within 90 days, We will not deny the claim because of late filing, provided proof was given as soon as reasonably possible. In any case, the direct claim form must be sent no later than 1 year from the time specified, unless the Covered Person is legally incapacitated.

Payment Of Claims

Benefits payable under this Policy will be directly to: (a) the Covered Person or (b) the Covered Person's legally appointed guardian if the Covered Person is not legally able to accept such benefits. In the event the Covered Person dies we will pay any benefits due and not assigned to the Covered Person's estate. Any payment made in good faith fully discharges us to the extent of that payment.

Time of Payment of Claims

After receiving written proof of loss, we will pay monthly all benefits then due. Benefits for any other loss covered by this Policy will be paid as soon as we receive proper written proof.

PAYMENT OF PREMIUMS

Computation of Premiums. Each monthly premium will be calculated on the basis of our record as to the number of Covered Persons in each coverage classification at the time of calculation, at the premiums then in effect.

Adjustments to Premiums. Retroactive adjustments may be made for any additions or terminations of Covered Persons and changes in coverage classification not stated in our records at the time the premium charges are calculated by us. If an addition is made effective before the **[**16th**]** day of the month then a full month's Premium will be charged. If an addition is made effective on or after the **[**16th**]** day of the month then no premium will be charged for that month. If a termination is made effective before the **[**16th**]** day of the month then no premium will be charged for that month. If a termination is made effective on or after the **[**16th**]** day of the month then a full month's premium will be charged for that month. The Policyholder is required to notify us of any changes using the appropriate paper or electronic notification. No retroactive credit will be given for any change occurring more than **[**30, 60, 90**]** days before our receipt of such notification. Claims paid after the termination date due to the retroactive termination will be recouped from the appropriate parties.

We have the right to change the premiums as follows:

1. on each Policy renewal date. We will give the Policyholder written notice of the change in premium rates at least **[**31 days**]** before the effective date of the change; and
2. on any date that the terms of this Policy are amended. We will give the Policyholder written notice of the change in Premium rates at least **[**31 days**]** before the effective date of the change**[**.**][**; and
3. on any date that the number of Covered Persons changes **[**by 10% or more**]**. We will give the Policyholder written notice of the change in premium rates.**]**

Payment. All premiums, including adjustments, must be paid to us by the Policyholder at our Home Office. These premiums are due as shown on the first page of this Policy. Once a premium is paid, insurance will be continued through the day prior to the next premium due date. The Policyholder may ask for a mode of payment that is one, two, four, or twelve times a year. This request must be approved by us. The Policyholder agrees to collect any employee contribution towards the premium.

Grace Period. A grace period of 31 days will be granted for the payment of premiums, during which this Policy will continue in force. In no event will any grace period extend beyond the date this Policy ends. The Policyholder will be liable to us for the premium payment that accrues for any period that this Policy is in force, including the grace period.

Late Payment Charge. If we do not receive any premium payments due under this Policy on or before the due date, the unpaid amount is subject to a late payment charge at the Monthly Interest Rate of **[**1,2,3,4,5**]** %. The Policyholder's payment of this late payment charge is not in lieu of automatic termination of this Policy as provided in Grace Period Section. We are entitled to both the unpaid premium payments and the late payment charge. We may, without prejudice, waive the late payment charge at any time. The Policyholder will also be responsible for the payment of all costs and expenses, including reasonable attorney's fees, incurred by us to collect any unpaid premiums from the Policyholder.

Reinstatement. Regardless of any contrary terms, if the Policyholder makes the proper premium payment plus late payment charges payable under this Policy to us after the end of the grace period, we may, at our sole option, reinstate this Policy without a lapse in coverage.

PARTICIPATION REQUIREMENTS

The Policyholder is enrolled with minimum participation requirements expressed as **[**10-50**]** percent of eligible Employees with a minimum of **[**10-25**]** Employees enrolled.

END OF THIS POLICY

Term of this Policy. This Policy will remain in force from the stated effective date and will continue under the same terms and conditions from year to year, unless it is ended or changed through an amendment or rider as provided in this Policy. The end of this Policy will not relieve the Policyholder from any obligation imposed upon it by the terms of this Policy for covered services rendered before the date this Policy ends, or relieve the Policyholder from any obligation incurred prior to the date this Policy ends. If this Policy ends, it will be the Policyholder's obligation to notify the Policyholder's Covered Persons regardless of the reason this Policy ends, except if we cease to offer this type of coverage.

Termination by Us. We may end this Policy at the end of any month by giving notice to the Policyholder for the following reasons only:

1. Nonpayment of Premiums. The Policyholder has failed to pay the required premiums, or has failed to pay premiums on a timely basis as set forth in the Premium Payment Section.
2. Fraud. The Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with coverage.
3. Violation of participation or the Policyholder's contribution requirements. The Policyholder has failed to comply with a material term of this Policy relating to any participation or contribution requirements. We will give the Policyholder **[**30-60**]** days prior written notice.
4. Termination of Coverage. We are ceasing to offer this type of coverage in the Policyholder's market. If we cease offering this type of coverage in the Policyholder's market, we will:
   a. give 90 days prior notice to the Policyholder and Covered Persons; and
   b. offer the Policyholder the option to purchase other coverage currently being offered by us; and
   c. act uniformly without regard to the Policyholder's claims experience or to any health status-related factor relating to any Covered Person covered or new employees and dependents who may become eligible for coverage.

Termination by the Policyholder. The Policyholder may end this Policy at any time by giving written notice to us **[**30-60**]** days prior to the requested termination date. All notices of termination should be sent via certified letter. In the event of termination, we will return promptly the unearned portion of any premium paid. Termination will be without prejudice to any claim originating before the effective date of termination.

Termination of Individual Coverage.

Coverage for a Covered Person shall automatically end on the earliest of the dates specified below:

1. the date this Policy is terminated;
2. the last day of the month in which the Eligible Person no longer meets eligibility requirements, unless an alternative date is otherwise stated in this Policy. The Eligible Person must notify us in writing within **[**30-60**]**1 days of a change, or termination of court or administrative ordered coverage;
3. the end of the period for which premium was last remitted for a Covered Person by the Policyholder if the Policyholder fails to remit premium when due;
4. the end of the period for which the last premium contribution is made, if premium contributions by the Eligible Person are required;
5. the date the Policyholder terminates the coverage for the Eligible Person's unit or class;
6. the last day of the month in which the Eligible Person is disabled, laid-off or on leave of absence.
7. the date the Eligible Person replaces this coverage with another health benefit plan;
8. the date specified by us in written notice to the Covered Person that all coverage under this Policy will end because the person misused his or her identification card, including but not limited to permitting a person not authorized by us to use the Identification Card to obtain covered services.

In addition, coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder.

Dependent Coverage, if applicable, will cease on the earliest of the following dates:
1. the date the Eligible Person is no longer in a Eligible Class for Dependent coverage; or
2. the date the Eligible Person or the Policyholder cease premium payments for Dependent coverage; or
3. the date we cancel all Dependent coverage under this Policy; or
4. the date the Eligible Person's coverage ceases.

In addition, Dependent's coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked by the Eligible Individual falls below the minimum required hours.

COBRA Coverage
A Covered Person whose coverage under this Policy would otherwise end may be entitled to elect continuation coverage under federal law or state law.

1. General Requirements:

   Continuation Coverage under COBRA applies only to employers which are subject to the provisions of COBRA. The Covered Person should contact the Policyholder's plan administrator to determine if the Covered Person is eligible to continue coverage under COBRA. We are not obligated to provide continuation coverage to a Covered Person if the Policyholder or its designated plan administrator fails to perform its duties under federal law. These duties include but are not limited to:
   (a) notifying the Covered Person in a timely manner of the right to elect continuation coverage; and
   (b) notifying us in a timely manner of the Covered Person's election of continuation coverage.

   We are not the Policyholder's designated plan administrator and do not assume any duties of a plan administrator pursuant to federal law.

   If the Covered Person chooses continuation coverage under a prior plan which was replaced by this Policy, the Covered Person's continued coverage shall terminate as scheduled under the prior plan or in accordance with the terminating events stated in item 4 below, whichever is earlier;

2. Qualifying events for COBRA Continuation Coverage:

   If the Covered Person's coverage terminates due to one of the following qualifying events, the Covered Person is entitled to continue coverage. The Covered Person may elect the same coverage that the Covered Person had at the time of the qualifying event. Qualifying events are:
   (a) Termination of the Eligible Person from employment with the Policyholder or reduction of hours, for any reason other than gross misconduct; or
   (b) Death of the Eligible Person; or
   (c) Divorce or legal separation from the Eligible Person; or
   (d) A Dependent child's loss of eligibility; or
   (e) Entitlement of the Eligible Person to Medicare benefits; or

(f) For a retired Eligible Person and his or her Dependents, the filing of Chapter 11 bankruptcy by the Policyholder;

3. COBRA Notification Requirements and Election Period:

The Covered Person must notify the Policyholder's designated plan administrator within 60 days of his or her divorce, legal separation or loss of eligibility as a Dependent.

Continuation must be elected by the later of:
(a) 60 days after the Covered Person's qualifying event occurs; or
(b) 60 days after the Covered Person receives notice of the continuation right from the Policyholder's designated plan administrator.

The Covered Person must pay the initial premium due to the Policyholder's designated plan administrator within 45 days after electing continuation. The Covered Person's monthly premium under COBRA may exceed the Group rate;

4. Terminating Events for COBRA Continuation Coverage:

COBRA continuation under this Policy will end on the earliest of the following dates:
(a) 18 months from the date continuation began, if the Covered Person's coverage ended because employment was terminated or hours were reduced. If a Covered Person is disabled at any time during the first 60 days of COBRA coverage, beginning on the day after termination of employment or reduction in hours, continuation coverage may be extended to a maximum of 29 months. Tthe Covered Person must give notice of the Covered Person's disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend coverage beyond 18 months. If the Covered Person provides such notice, the Covered Person's coverage may be extended up to a maximum of 29 months from the date of such qualifying event or until the first month that begins more than 30 days after the date of any final decision that the Covered Person is no longer disabled. If the disabled Covered Person has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29 month disability extension. A Covered Person must provide notice of any final determination that he or she is no longer disabled within 30 days of such determination;
(b) 36 months from the date continuation began for a Dependent whose coverage ended because of the death of the Eligible Person, divorce or legal separation from the Eligible Person, loss of eligibility by a Dependent child or entitlement of the Eligible Person to Medicare benefits, in accordance with qualifying events 2b through 2e above;
(c) The date coverage terminates under this Policy for failure to make timely payment of the premium;
(d) The date coverage is obtained under any other group health plan. If such coverage has a limitation or exclusion with respect to a Covered Person's pre-existing condition, continuation will end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health care except health care which is subject to the pre-existing condition limitation or exclusion. If the other group health plan's pre-existing condition limitations or exclusions cannot be applied because of the restrictions under the Health Insurance Portability and Accountability Act of 1996, then COBRA continuation will end on the date the Covered Person became covered under the other group health plan;
(e) The date the Covered Person becomes entitled to Medicare, except that this will not apply if the coverage was terminated because the Policyholder filed for bankruptcy, in accordance with qualifying event 2f of Section (2) above;

(f) The date this Policy terminates;
(g) The date coverage would otherwise terminate under this Policy.

If the Covered Person's coverage ended because employment was terminated or hours reduced as described in item 2a above, and during the 18 month continuation period a second qualifying event occurs, coverage may be extended up to a maximum of 36 months. The 36 month period starts from the date coverage ended due to the first qualifying event. If the Covered Person is entitled to continuation because the Policyholder filed for bankruptcy, as described in item 2f above and the retired Eligible Person dies during the continuation period, the Dependents are entitled to continue coverage for 36 months from the date of death. Terminating events 4b through 4g shall apply during any extended continuation period.

A Dependent whose continuation coverage terminates because the Eligible Person becomes entitled to Medicare should contact the Policyholder's designated plan administrator for information regarding an extension of continuation coverage for an additional period of time.

[Continuation coverage under COBRA is not available to Domestic Partners, if Domestic Partner coverage is available to the Covered Person.**]**

ADMINISTRATION OF THIS POLICY

Forms. We will supply the Policyholder with a reasonable supply of its forms and descriptive materials for distribution to employees. The Policyholder will give our forms and descriptive materials to any employee who becomes eligible for coverage under this Policy. Group agrees to forward all applicable forms, including Enrollment Forms, and other required information to us within **[**10-20**]** business days of receipt from an employee.

Records. The Policyholder agrees to make payroll and other records directly related to Covered Persons' coverage under this Policy available to us for inspection at our expense, at the Policyholder's office, during regular business hours upon reasonable advance request by us. This Records Section will survive the end of this Policy as needed to resolve outstanding financial or administrative issues under this Policy.

GENERAL PROVISIONS

Conformity with State Statutes. If any part of this Policy does not conform to a statute in the state in which it is issued or delivered, it is amended to conform with the minimum statutes of that state.

Disclosure to Policyholder. At the request of a Policyholder, we may provide summary health information to the Policyholder for purposes of 1) obtaining premium bids, or 2) modifying, amending or terminating this Policy. In addition, if the Policyholder 1) amends its summary plan description and 2) provides certification to us that such amendment has been made, detailed health information may be released without summarizing the information. Additionally, we may disclose to the Policyholder information on whether the individual is participating in this Policy.

Individual Certificates. We will give to the Policyholder a certificate for each employee who is entitled to insurance under this Policy. It explains the main benefits and requirements of this Policy. It lists any limitations on coverage. It tells the Covered Person how to make a claim against this Policy.

Governing Law. This Policy is delivered in and governed by the laws of the state noted on the first page of this Policy.

Legal Actions. No action at law or in equity may begin prior to 60 days after we receive a valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

New Employees. New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible. Completion of the enrollment process or waiver of coverage must be obtained from each employee.

Notice to Policyholder. Written notice given by us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of this Policy, including termination of this Policy and termination of individual coverage under this Policy.

Right to Receive and Release Necessary Information. In implementing and determining the applicability of the terms of this Policy, we may release to, or obtain from, any other insurance company, organization or person any other information with respect to any person which we deem necessary for such purposes. Any person claiming benefits under this Policy is required to furnish us such information and/or cooperation as may be necessary to implement this provision.

Waiver of Rights. If we fail to enforce any provision of this Policy, such failure will not affect our right to do so at a later date, nor will it affect our right to enforce any other provision of this Policy.

Workers' Compensation Not Affected. This Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

Important Notice. If the Policyholder has any questions or concerns about coverage under this Policy or if the Policyholder would like to make any comments or complaints, please call **[**1-800-XXX-XXXX**]**.

[ERISA

If this Policy is being purchased to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. Section 1001 et seq., We are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.**]**

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**
(Hereafter called we, us or our)

CERTIFICATE OF COVERAGE

PRESCRIPTION DRUG COVERAGE

INSURING AGREEMENT

Stonebridge Life Insurance Company has issued a Policy covering certain Eligible Classes of the Policyholder. The benefits of the Policy are described in this Certificate. Final interpretation is governed by the Policy. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy. This Certificate describes the Policy in detail.

NOTICE CONCERNING YOUR CERTIFICATE

The benefits and provisions of the Policy are described in this Certificate. However, you only have the benefits outlined in the Certificate provided Eligibility and Enrollment requirements described herein are satisfied, and any required Premium is paid.

Please read Your Certificate carefully. Keep it in a safe place.

Craig D. Vermilye
Secretary

Marilyn Carp
President

TABLE OF CONTENTS

[CERTIFICATE INFORMATION

Group: [ABC Company] **Group Policy Number: [02-000000]**

Certificate Number: [0000000000]

Covered Person: [John Doe] **Effective Date of Coverage: [mm/dd/yy]**

Spouse: [None] **Effective Date of Coverage: [mm/dd/yy]**

Dependent(s): [None] **Effective Date of Coverage: [mm/dd/yy]]**

INTRODUCTION

This Certificate describes your coverage under Stonebridge Life Insurance Company. This Certificate outlines the terms of your coverage under the Policy signed by the Policyholder. It is not the entire Policy. The Policy and the Group Application are available at the Policyholder's office for your inspection at reasonable times.

How to Use This Certificate. Please read this Certificate carefully. Become familiar with its terms. Many of the Certificate terms are related. Just reading one or two sections may give you a misleading impression. Many terms in this Certificate have special meaning. These words will appear with their first letter capitalized, and are defined in the Certificate. The terms "you" and "your" as used throughout this Certificate mean the Eligible Person. By using these definitions, you will get the clearest picture of what is being said. From time to time, this Certificate will be amended. When that happens, an amendment or rider will be sent to you. Keep the Certificate and any amendments and riders in a safe place for future reference.

Benefits under the Policy are subject to certain limitations and restrictions. In order to optimize benefits, please carefully read and ensure you understand the terms of the Policy, including Prior Notification. If you have any questions, or need further help, please call us at **[**the number on your ID card**]**.

ELIGIBILITY AND EFFECTIVE DATE FOR YOU

Who is eligible?
You are eligible if you are included in an Eligible Class listed in the Application and you are:
1. performing all the normal duties of your job at the normal place of business of the Policyholder;
2. working in an Eligible Class shown in the Application;
3. working the minimum required hours at the normal place of business of the Policyholder;
4. **[**if you are retired from the Policyholder, under age 65 and not enrolled in Medicare; and**]**
5. you do not have an insurance plan that provides drug benefits.

How do I enroll?
If you meet all eligibility requirements of the Policyholder prior to the Effective Date of the Policy you may request enrollment during the enrollment period that precedes the Effective Date of the Policy. If you do not enroll during this period you will be considered a Late Enrollee. This enrollment period is determined between us and the Policyholder.

After the Effective Date of the Policy, if you do not request enrollment during the following time periods or during a special enrollment period you will be considered a Late Enrollee:
1. if the Policy has a Waiting Period, enrollment must be requested no later than **[**31 days**]** after the end of the Waiting Period;
2. if the Policy does not have a Waiting Period, enrollment must be requested no later than **[**31 days**]** after the date of hire.

Waiting Periods are described in this Certificate.

Enrollment is made by completing the enrollment process, as specified. You may enroll for **[**single, Eligible Person and Spouse, Eligible Person and Dependent, or Eligible Person and family. "Single" covers the Eligible Person only. "Family" covers the Eligible Person, Spouse, and your eligible Dependents.**]** You cannot also enroll as a Dependent under the Policy.

When do I cease to be eligible?
You shall cease to be an Eligible Person on the first day of the month following any month in which the number of hours worked falls below the minimum required hours **[**or you reach age 65 and become enrolled in Medicare**]**.

When will I become covered?
Your coverage will take effect on the later of:
1. the Effective Date of the Policy; or
2. the **[**first day of the month that next follows the**]** date you complete the Waiting Period, if any, as long as enrollment is requested within 31 days after the end of the Waiting Period. If the Waiting Period ends on the first day of the month, coverage will begin on that day, if you enroll during the Waiting Period; or
3. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

You must complete the enrollment process. If you are required to pay all or part of the premium for coverage, you must acknowledge your permission to the Policyholder to withhold such premium from your pay.

[Waiting Period
The Waiting Period for an Eligible Person who is not a Late Enrollee is **[**30-60 days. The Waiting Period will begin **[**on your date of hire or the date you qualifies as an Eligible Person**]**. A Late

Enrollee can only enroll during the Policyholder's annual enrollment period, which is held once each calendar year and is held open for **[**30-90**]** consecutive days.**]**

Special Enrollments

If you decline coverage or decline coverage for your Dependents because of other coverage, you or your Dependents may enroll for coverage in the future during the special enrollment period described in paragraph A below.

In addition, if you acquire a new Dependent due to marriage, birth, adoption, placement for adoption **[**or new Domestic Partnership**]**, you and your Dependents may enroll for coverage during the special enrollment period described in paragraph B below.

A. Special Enrollment Period - Loss of other coverage:

If you or your Dependents:

1. failed to enroll when first eligible for coverage;
2. lose other health coverage; and
3. are otherwise eligible for coverage under the Policy,

you or your Dependents may enroll for coverage under the Policy, but only if the following conditions are met:

1. the person was covered under a health plan at the time coverage under the Policy was first offered to the person;
2. the person stated in writing the reason for declining coverage was due to coverage under another health plan;
3. If the other health coverage was:
   (a) COBRA continuation coverage, the COBRA continuation coverage has been exhausted for reasons other than failure to pay timely premiums or for cause; or
   (b) other than COBRA continuation coverage, the coverage was either terminated due to loss of eligibility for coverage or the current or former employer terminated contributions towards the other coverage. Loss of eligibility for coverage includes a loss due to legal separation, **[**dissolution of Domestic Partnership,**]** divorce, death, termination of employment or reduction in the number of hours of employment. Loss of eligibility does not include loss due to failure to pay timely premiums or termination of coverage for cause; and
4. The person requests enrollment under the Policy not later than 30 days after the date the other coverage ended or the employer's contributions terminated.

Coverage under the Policy will become effective on the first day of the month following the date we receive the completed request for enrollment; or on an earlier date, as agreed to by us.

B. Special Enrollment Period - Change in Family Status

If you or your Dependents:

1. failed to enroll when first eligible for coverage;
2. are otherwise eligible for coverage under the Policy; and
3. you acquire a Dependent through marriage, **[**Domestic Partnership,**]** birth, adoption, or placement for adoption,

we will provide a special enrollment period for coverage as described below.

The special enrollment period is for 30 days and begins on the later of:

1. the date Dependent Coverage is made available under the Policy; or
2. the date of marriage or termination of marriage, **[**Domestic Partnership or termination of Domestic Partnership,**]** birth, adoption or placement for adoption.

During the special enrollment period, you may request enrollment for single coverage or family coverage for eligible Dependents who are not already enrolled under the Policy.

If enrollment is requested during this special enrollment period, coverage will be effective:

1. in the case of marriage **[**or Domestic Partnership**]**, on the first of the month following the date we receive the completed request for enrollment; or
2. in the case of a Dependent's birth, on the date of such birth; or
3. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Reinstatement after Release from Active Duty

If coverage ends due to you being called or ordered to active duty as a reservist, such coverage will be reinstated without any Waiting Period when you return to Eligible Person status or when the Dependent is no longer on active duty.

Reinstatement after Termination of Employment

If coverage ends due to termination of employment and the employee later becomes employed by the Policyholder, you must meet all requirements of a new employee before coverage will become effective.

ELIGIBILITY AND EFFECTIVE DATE FOR DEPENDENTS

Is my Dependent eligible?
Dependents are eligible if:
1. you are in a class that qualifies for Dependent benefits; and
2. you make a written request giving any information we may require; and
3. the Dependent is not in an Eligible Class.

A person may not be covered more than once under the Policy at the same time. If both husband and wife are covered under the Policy, either, but not both, may elect to cover their eligible Dependent children.

How do enroll a Dependent?
If the Policy provides for family coverage, you may request enrollment of your Dependents:
1. at the time you request enrollment for yourself; or
2. when you acquire a new Dependent; or
3. during a special enrollment period.

Proof of the Dependent relationship may be required by us. A Dependent that is not enrolled as described above will be considered a Late Enrollee. A Dependent cannot be enrolled prior to the date you have enrolled for coverage under the Policy.

A person may be enrolled as a Dependent if he or she is:
1. your Spouse; or
2. your Dependent child.
3. **[**your Dependent Domestic Partner and the children of the Domestic Partner. A person may be enrolled as a Domestic Partner, or the Domestic Partner's children may be enrolled, if he or she provides us with a copy of a valid Declaration of Domestic Partnership that has been filed with the Secretary of State or has filed an Affidavit of Domestic Partnership with us and is meeting the requirements set forth by us for Domestic Partnership coverage and meets the definition of Dependent as defined**]**.

If a court or administrative order requires you to provide health care coverage for your child and the Policy provides for family coverage, we will:
1. Allow you to enroll such child under family coverage if the child is otherwise eligible and not apply any enrollment period restrictions; or
2. Allow the child's other parent to enroll the child if you fail to enroll the child for family coverage.

When will my Dependent become covered?
Coverage for a Dependent will take effect on the later of:
1. the date your coverage with us begins; or
2. the day you enroll your Dependent, if enrollment is requested within 31 days of the date the Dependent is acquired; or
3. the date specified in the Special Enrollments section; or
4. the date you acquire that new Dependent if the Eligible Person has family coverage at that time and no additional premium is required; or
5. for a Late Enrollee, the Policyholder's next annual enrollment period, if any.

The above provisions do not apply to newborn children, adopted children, children placed for adoption, and children for whom coverage is ordered by a court. Requirements for those children are

described in the following sections. In no event will coverage for a Dependent begin prior to the date your coverage begins.

Newborn and Adopted Children/Children Placed for Adoption.
Coverage for your newborn child, or a child adopted by or placed for adoption with you will take effect on the later of:

1. the date your coverage begins with us; or
2. the moment of birth of the newborn or the date of adoption or date of placement of the child. Coverage is provided for 31 days from the date of birth, adoption or placement. In order to continue coverage beyond the 31 day period, you must enroll the child within 31 days of the date of birth, adoption or placement and pay any required additional premium. Any required premium must be paid when due from the date of birth, adoption or placement. If the enrollment and premium payment procedures are not followed, coverage will not continue beyond the 31 day period.

Date of Placement means the date of assumption and retention by you of a legal obligation for total or partial support of a child to be adopted.

Court Ordered Coverage.
If your child is enrolled as the result of a court order or administrative order, coverage for such child shall take effect on the date of enrollment once the required premium, if any, has been paid.

Dependent Status Change.
You must inform us or the Policyholder within 31 days of any Dependent change in family status.

Special Enrollments
If you decline coverage or decline coverage for your Dependents because of other coverage, you or your Dependents may enroll for coverage in the future during the special enrollment period described in paragraph A below.

In addition, if you acquire a new Dependent due to marriage, birth, adoption, placement for adoption **[**or new Domestic Partnership**]**, you and your Dependents may enroll for coverage during the special enrollment period described in paragraph B below.

A. Special Enrollment Period - Loss of other coverage:
   If you or your Dependents:
   4. failed to enroll when first eligible for coverage;
   5. lose other health coverage; and
   6. are otherwise eligible for coverage under the Policy,

   you or your Dependents may enroll for coverage under the Policy, but only if the following conditions are met:
   5. the person was covered under a health plan at the time coverage under the Policy was first offered to the person;
   6. the person stated in writing the reason for declining coverage was due to coverage under another health plan;
   7. If the other health coverage was:
      (a) COBRA continuation coverage, the COBRA continuation coverage has been exhausted for reasons other than failure to pay timely premiums or for cause; or
      (b) other than COBRA continuation coverage, the coverage was either terminated due to loss of eligibility for coverage or the current or former employer terminated contributions towards the other coverage. Loss of eligibility for coverage includes a loss due to legal separation, **[**dissolution of Domestic Partnership,**]** divorce, death, termination of

employment or reduction in the number of hours of employment. Loss of eligibility does not include loss due to failure to pay timely premiums or termination of coverage for cause; and

8. The person requests enrollment under the Policy not later than 30 days after the date the other coverage ended or the employer's contributions terminated.

Coverage under the Policy will become effective on the first day of the month following the date we receive the completed request for enrollment; or on an earlier date, as agreed to by us.

B. Special Enrollment Period - Change in Family Status

If you or your Dependents:

4. failed to enroll when first eligible for coverage;
5. are otherwise eligible for coverage under the Policy; and
6. you acquire a Dependent through marriage, **[**Domestic Partnership,**]** birth, adoption, or placement for adoption,

we will provide a special enrollment period for coverage as described below.

The special enrollment period is for 30 days and begins on the later of:

3. the date Dependent Coverage is made available under the Policy; or
4. the date of marriage or termination of marriage, **[**Domestic Partnership or termination of Domestic Partnership,**]** birth, adoption or placement for adoption.

During the special enrollment period, you may request enrollment for single coverage or family coverage for eligible Dependents who are not already enrolled under the Policy.

If enrollment is requested during this special enrollment period, coverage will be effective:

4. in the case of marriage **[**or Domestic Partnership**]**, on the first of the month following the date we receive the completed request for enrollment; or
5. in the case of a Dependent's birth, on the date of such birth; or
6. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

DEFINITIONS

Throughout this Certificate, when a term which has been capitalized, its meaning may be found in this section.

AGE
Age at last birthday.

APPLICATION
A form completed by Policyholder in applying for coverage under the Policy.

AWP
The average wholesale price of the Covered Drug, as set forth in the current price list in nationally recognized sources determined by Pharmacy Benefit Manager.

BENEFIT
The dollar amount payable by us to a Claimant under the Policy.

BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

CLAIMANT
A person making a claim under the Policy.

COMPOUND PRESCRIPTION
A prescription that meets the following criteria: two or more solid, semisolid, or liquid ingredients, at least one of which is a Covered Drug, that are weighed or measured then prepared according to the Prescriber's order and the Pharmacist's art.

CO-PAYMENT
The amount a Covered Person must pay for each Prescription or authorized refill. This amount, if any, is shown on the Plan Benefit Schedule in the Prescription Drug Benefits Provision and must be paid to the Provider at the time the services are received.

[COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]].]**

COVERED DRUGS
All FDA-approved, Legend Drugs including Generic Drugs, Brand-name Drugs, **[**and**]** Specialty Drugs**[**, Preferred Brand-name Drugs,**][** Non-Preferred Brand-name Drugs,**][** Covered Brand-name Drugs,**][** and**][** Non-Covered Brand-name Drugs**]** (except those listed in the General Exclusions and Limitations section of this Policy) that are prescribed by a Prescriber. The list of Covered Drugs is subject to periodic review and modification. The latest list of Covered Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

COVERED PERSON
You or your Dependent, who has enrolled for coverage and for whom premium has been paid to us, so long as coverage of such person under the Policy is in effect.

DEPENDENT
A person who may become covered or is entitled to benefits under the Policy and must be verified by the Policyholder if they are one of the following:
Your:
1. Spouse (if not legally separated or divorced from you).
2. **[**Domestic Partner.**]**
3. A child from the moment of birth, until the end of the calendar year that the child attains Age 19.
4. A child who is a student may be covered until the end of the calendar year that the child attains Age 25 provided such child is:
   (a) A Full-Time Student **[**or part-time student**]** or living in your household; and
   (b) More than 50% dependent on you for support and maintenance.
   (c) Proof of the child's enrollment as a student must be submitted to us.
5. Handicapped child who has attained either limiting Age shown above, if such child is:
   (a) Mentally retarded or physically incapable of earning their own living; and
   (b) Dependent on you for support and maintenance; and
   (c) Was covered on the day immediately prior to attaining the limiting Age.

Proof of incapacity must be furnished to us within 31 days of attainment of the limiting Age or qualifying event.

Children include a stepchild, adopted child, a child placed for adoption, or a child under the guardianship of you or your Spouse who are dependent upon you for support or a child for whom you are required to provide coverage by a court or administrative order. A foster child or a child who is a ward of the court is not considered to be a Dependent. A Dependent or Domestic Partner cannot also be enrolled as an Eligible Person under the Policy.

DISCOUNTED PRICE
The price that the Pharmacy Benefit Manager has negotiated for the medication, resulting in a price lower than AWP.

[DOMESTIC PARTNER
Two individuals who, together, each meet all of the following criteria set forth below:
1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the domestic partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
   (a) living together as a couple;
   (b) mutual support of each other;
   (c) mutual caring and commitment to each other;
   (d) mutual fidelity;
   (e) mutual responsibility for each other's welfare; and
   (f) joint responsibility for the necessities in life.

8. Have been living together as a couple for at least 6 months prior to obtaining the coverage provided under the Policy.
9. Intend to continue the domestic partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.**]**

ELIGIBLE CLASS
A description of Eligible Persons meeting all eligibility requirements in the Policy that is shown in the Application.

ELIGIBLE PERSON
You, whose employment or whose status with the Policyholder is the basis for eligibility for coverage under the Policy and who meets the enrollment rules. You cannot also be enrolled as a Dependent under the Policy.

EMPLOYEE
A person who is employed by**[**, or retired from and under Age 65 and not enrolled in Medicare**]** and paid by the Policyholder.

[ENROLLMENT PERIOD
The timeframe as defined by the Policy within which you may request coverage under the Policy. The following are the Enrollment Periods available to you under the Policy:
1. Initial enrollment period is a **[**30-90**]** day period after the effective date of the Policy when you may request enrollment for coverage under the Policy.
2. Annual Enrollment Period is the **[**month each calendar year**]** when you may request enrollment for coverage under the Policy.
3. Special Enrollment Period is a **[**30-90**]**-day period, based on qualifying events, when you may request enrollment for coverage under the Policy.**]**

FULL-TIME STUDENT
A person who is enrolled in and attending, on a full-time basis, a recognized course of study or training at: (1) an Accredited high school or vocational school; (2) an Accredited college or university; (3) a licensed technical or trade or similar training school, which offers general education classes. Full-Time Student status is determined by the standards set forth by the school, college or university. A person ceases to be a Full-Time Student at the end of the calendar month during which the person graduates or ceases to be enrolled and in attendance on a full-time basis. A person continues to be a Full-Time Student during periods of vacation established by the school, college, or university if he or she was a Full-Time Student on the day before the start of the vacation period. “Accredited” means the school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S. Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC. We may require proof of Full-Time Student status.

GENERIC DRUG
A multisource Generic Drug set forth in the Pharmacy Benefit Manager’s list of Generic Drugs, as reasonably determined by the Pharmacy Benefit Manager, and that is available in sufficient supply from multiple manufacturers. The list is subject to periodic review and modification. The latest list of Generic Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

LATE ENROLLEE
You or your Dependent who has declined coverage under a plan offered by the Policyholder at the time of the initial enrollment period provided under the terms of the plan, and who subsequently

requests enrollment in a plan of that the Policyholder, provided that the initial enrollment period shall be a period of at least **[**30-90**]** days. However, you or your Dependent shall not be considered a Late Enrollee if any of the conditions defined in the Special Enrollments Section are applicable.

LEGEND DRUGS
A drug that is required by federal or state law, to be dispensed pursuant to a prescription or order by an authorized Prescriber.

MAIL ORDER PHARMACY
The Pharmacy Benefit Manager's licensed mail order pharmacy subsidiaries, which provide prescription drugs via a mail order service.

[NON-COVERED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Covered Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Covered Brand-name Drug, refer to the latest list of Non-Covered Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.**]**

[NON-PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Non-Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. To determine whether a specific Brand-name Drug is considered a Non-Preferred Brand-name Drug, refer to the latest list of Non-Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.**]**

PARTICIPATING RETAIL PHARMACY
A retail pharmacy that has entered into an arrangement with the Pharmacy Benefit Manager that specifies the terms and conditions of the pharmacy's participation, including the rates that the Pharmacy Benefit Manager will pay the pharmacy.

PHARMACIST
An individual who is currently licensed in accordance with applicable law and regulations to engage in the practice of pharmacy.

PHARMACY
A site, properly licensed in accordance with applicable law and regulations, where drugs are dispensed or pharmaceutical care is provided by a licensed pharmacist.

PHARMACY BENEFIT MANAGER
The entity that administers and manages this generic prescription drug coverage program and, in connection therewith, has established networks of participating retail pharmacies and operates a system for the processing fulfillment and payment of claims for prescription drugs furnished by such pharmacies.

[PREFERRED BRAND-NAME DRUGS
All brand drugs set forth in the Pharmacy Benefit Manager's list of Preferred Brand-name Drugs, as reasonably determined by the Pharmacy Benefit Manager. The list is subject to periodic review and modification. The latest list of Preferred Brand-name Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.**]**

PRESCRIBER
A duly licensed health care practitioner who is authorized by law to write prescriptions or medication orders intended for the treatment or prevention of disease.

SPECIALTY DRUGS
Pharmaceutical products that are reasonably determined by the Pharmacy Benefit Manager to be biotechnological in nature and are used to treat certain conditions. The list is subject to periodic review and modification. The latest list of Specialty Drugs can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

SPOUSE
Your legal husband or wife as recognized by state law.

USUAL AND CUSTOMARY
The price that a Pharmacy charges a customer who does not have any form of prescription drug coverage.

[WAITING PERIOD
The period of time required by the Policyholder which must pass before coverage begins under the Policy for an Eligible Person.**]**

PRESCRIPTION DRUG BENEFITS PROVISION

The following Plan Benefit Schedule describes what the Covered Person will pay for Covered Drugs through the Pharmacy Benefit Manager or at a Participating Retail Pharmacy. Covered Drugs include all FDA-approved, Legend Drugs (except those listed in the General Exclusions and Limitations section) that are prescribed by a Prescriber.

Plan Benefit Schedule

[[Plan 1 – [Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 2 – [Super Value Generic]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 0: **[**$0**]** Co-payment Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 0: **[**N/A**]** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Brand-name Drugs	**[**100%**]** of a discounted amount
Specialty Drugs	**[**100%**]** of a discounted amount

[[Plan 3 – [Value Generic with Preferred Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Preferred Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Monthly Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any

	Brand-name cost differential**]**
Specialty and Non-Preferred Brand-name Drugs	**[**100%**]** of a discounted amount

[[Plan 4 – [Value Generic with Managed Brand Wrap]

Generic Drugs	***Participating Retail Pharmacy (up to a [30] day supply)*** Tier 1: **[**$3.99**]** Co-payment Tier 2: **[**$10**]** Co-payment ***Mail Order (up to a [90] day supply)*** Tier 1: **[**$10**]** Co-payment Tier 2: **[**$25**]** Co-payment
Covered Brand-name Drugs	**[**Co-payment**]** *or* **[**Coinsurance**]**: **[**$25-50**]** *or* **[**25%-50%**]** **[**Deductibles: **[**$0-50**]** Individual / **[**$0-100**]** Family **[**Annual Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Monthly Plan Maximum: **[**$0-50**]** Individual / **[**$0-100**]** Family**]** **[**Mandatory Generic: Individual responsible for Generic Co-payment and any Brand-name cost differential**]**
Specialty and Non-Covered Brand-name Drugs	**[**100%**]** of a discounted amount

The list of Generic, Brand-name and Specialty Drugs, and any additional drug and/or Tier, has been agreed to by the Policyholder, the Pharmacy Benefit Manager and us. The list is subject to periodic review and modification. The list can be obtained by a Covered Person by contacting the Pharmacy Benefit Manager by **[**calling **[**1-800-XXX-XXXX**]]**.

Participating Retail Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Participating Retail Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Mail-Order Pharmacy

- **Generic Drugs:** For each Generic Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the tier and supply reflected in the Plan Benefit Schedule above. If the Generic Drug is considered a Specialty Drug, the pricing for Specialty Drugs applies.**]**
- **Brand-name Drugs:** For each Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **Specialty Drugs:** For each Specialty Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Specialty Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Preferred Brand-name Drugs:** For each Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Preferred Brand-name Drug, and the Preferred Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-

payment for the supply in addition to the AWP cost differential between the Generic Drug and the Preferred Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**

- **[Non-Preferred Brand-name Drugs:** For each Non-Preferred Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Preferred Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**
- **[Covered Brand-name Drugs:** For each Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, **[**after satisfaction of any Deductible shown in the Plan Benefit Schedule above,**]** the Covered Person will pay **[**the lesser of Usual and Customary charge or**]** the Co-payment or coinsurance amount for the supply reflected in the Plan Benefit Schedule above. **[**Where a Generic Drug equivalent is available for the Covered Brand-name Drug, and the Covered Brand-name Drug is purchased, the Covered Person will pay the Generic Drug Co-payment for the supply in addition to the AWP cost differential between the Generic Drug and the Covered Brand-name Drug.**]** **[**This benefit is subject to a **[[**Annual**][**Monthly**]]** Plan Maximum as reflected in the Plan Benefit Schedule above.**]]**
- **[Non-Covered Brand-name Drugs:** For each Non-Covered Brand-name Drug prescription purchased at a Mail-Order Pharmacy, the Covered Person will pay the coinsurance amount reflected in the Plan Benefit Schedule above of the Non-Covered Brand-name Drug AWP less a discounted amount as determined by the Pharmacy Benefit Manager and us. Certain discount exceptions apply. **[**A **[**$XX**]** dispensing fee is added to each order.**]**

Filling a Prescription at a Participating Retail Pharmacy

In order to fill a prescription at a Participating Retail Pharmacy, the Covered Person will submit the Covered Person's prescription along with the Covered Person's prescription drug ID card to the Pharmacist at the Participating Retail Pharmacy. The Pharmacist will dispense the Covered Drug to the Covered Person and charge the Covered Person the appropriate amount.

Filling a Prescription at the Mail Order Pharmacy

In order to fill a prescription at the Mail Order Pharmacy, the Covered Person will fill-out a Mail Order Pharmacy order form and mail the completed form, the prescription, and the Covered Person's payment option to the Mail Order Pharmacy. In certain circumstances, the Covered Person may also have the Covered Person's Prescriber fax the Covered Person prescription to Mail Order Pharmacy. The Covered Person's prescription will be filled and the Covered Person will be charged the appropriate amount in accordance with the payment option the Covered Person has selected. Once filled, the prescription will be delivered to the Covered Person's home or office, by mail, usually within **[**10**]** days after Mail Order Pharmacy receives the Covered Person's initial prescription and **[**7**]** days after Mail Order Pharmacy receives the Covered Person's re-fill prescription. Mail Order Pharmacy will dispense Covered Drugs to the Covered Person in accordance with applicable law and regulations in the state in which Mail Order Pharmacy is located. Any prescriptions that are not dispensed will be returned to the Covered Person with an explanation as to why it could not be dispensed in accordance with Mail Order Pharmacy's standard operating procedures.

GENERAL EXCLUSIONS AND LIMITATIONS

We will not pay for:

1. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after 1 year from the Prescriber's original order.
2. Any quantity of medications dispensed for more than a **[**30-60**]**-day supply from a Participating Retail Pharmacy or **[**90-120**]**-day supply through the Pharmacy Benefit Manager.
3. Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the Covered Person.
4. Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
5. Federal and Non-Federal Legend Non-Drugs.
6. Charges for the administration or injection of any drug.
7. Substance abuse treatment.
8. Therapeutic devices and appliances.
9. Prescriptions for household pets.

[10. Medications not dispensed by a Participating Retail Pharmacy or the Pharmacy Benefit Manager.**]**

[11. The following drugs (both the Brand-name Drugs or Generic Drugs) are only available at the Brand-Name drugs pricing noted in the Plan Benefit Schedule section:

- Single source generic drugs i.e., those available from only a single manufacturer
- Impotence and erectile function medications
- Smoking deterrents (except Zyban®)
- Anti-obesity medications
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.**]**

[12. Isotretinoin products (Brand-name Drugs and Generic Drugs) including Accutane®, Amnesteem®, Sotret® and Claravis™.**]**

[13. Over-the-counter drugs and vitamins.**]**

[14. Ostomy supplies.**]**

[15. Non-systemic contraceptives, devices, implants, and injections.**]**

[16. Compound prescription drug products.**]**

[17. Topical fluoride products.**]**

[18. GlucoWatch®/GlucoWatch® Sensors.**]**

[19. Drugs labeled "Caution—limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.**]**

[20. Fertility Agents (except those Specialty Drugs which may be subject to the Generic Drug Benefits section).**]**

[21. Injectable Medications (except Brand-name Insulin & those which are Specialty Drugs subject to the Prescription Drug Benefits Provision).**]**

[22. Biologicals, Immunization Agents, Vaccines, Allergy Sera, Blood or Blood Plasma Products (except those Specialty Drugs which may be subject to the Prescription Drug Benefits Provision).**]**

[23. Other drugs as determined by us and the Pharmacy Benefits Manager. We will provide 60 days notice before adding a drug to this list of exclusions.**]**

Benefits are not provided for expenses which result directly or indirectly, wholly or partly from:

1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.
2. Declared or undeclared war or acts thereof.
3. Serving on full-time active duty in any armed forces of any country or international authority (any premium paid will be returned by us pro-rata for any period of active-full time duty).
4. Any Workers' Compensation Act, Occupational Disease law or similar law under which benefits were paid or received by the Covered Person.
5. The Covered Person operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
6. Charges for which:
   - there is no legal obligation to pay, or
   - no charge is made, or
   - in the absence of coverage, no charge would be made.
8. Charges incurred after coverage terminates under the Policy.
9. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
10. Charges for services which are not related to and consistent with the treatment of the Covered Person.

CLAIMS PROVISION

Direct Claim Process
The Covered Person will be able to submit a direct claim to the Pharmacy Benefit Manager in the event that the Covered Person pays the Usual and Customary price for the Covered Person's first purchase of a Generic Drug at a Participating Retail Pharmacy. For example, for the Covered Person's first purchase of Generic Drug, the Covered Person may forget to submit the Covered Person's prescription drug ID card to the Participating Retail Pharmacy, thus causing the Participating Retail Pharmacy to charge the Covered Person its Usual and Customary price for the Generic Drug (rather than the applicable Co-payment), In such event, the Covered Person may submit a direct claim to the Pharmacy Benefit Manager for reimbursement. The Covered Person may submit a direct claim by completing a direct claim form, with the receipt attached, and mailing it to Pharmacy Benefit Manager for processing and approval. Reimbursement will be based on the amount the benefit would have paid, less any applicable Co-payment.

Coordination of Benefits
There will be no Coordination of Benefits for allowed pharmacy charges between the Policy and another pharmacy/medical plan in which the Covered Person may be enrolled.

Notice of Claim
Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to the Pharmacy Benefits Manager at their home office or to the Pharmacy Benefits Manager's agent. Notice should include the name of the Covered Person and the policy number.

Proof of Loss
If it is necessary to submit a direct claim form, it must be given to the Pharmacy Benefit Manager within 90 days of the claim. If it was not possible for the claim form to be given within 90 days, We will not deny the claim because of late filing, provided proof was given as soon as reasonably possible. In any case, the direct claim form must be sent no later than 1 year from the time specified, unless the Covered Person is legally incapacitated.

Payment Of Claims
Benefits payable under the Policy will be directly to: (a) the Covered Person or (b) the Covered Person's legally appointed guardian if the Covered Person is not legally able to accept such benefits. In the event the Covered Person dies we will pay any benefits due and not assigned to the Covered Person's estate. Any payment made in good faith fully discharges us to the extent of that payment.

Time of Payment of Claims
After receiving written proof of loss, we will pay monthly all benefits then due. Benefits for any other loss covered by the Policy will be paid as soon as we receive proper written proof.

PAYMENT OF PREMIUMS

Individual Premium Due Dates: The first premium for each Covered Person is due on the date the Covered Person becomes covered under the Policy. Each premium after the initial premium is due at the end of the period for which the Covered Person's preceding premium was paid.

Individual Grace Period: A grace period of 31 days from the Individual Premium Due Date is allowed for payment of each premium due after the initial premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, you will be liable to us for payment of any premium accruing during the period we continue coverage in force under this provision. The Grace Period will not continue beyond a date stated in a Termination provision.

Change of Policy Premiums: We have the right to change the premiums as follows:

1. on each Policy renewal date. We will give the Policyholder written notice of the change in premium rates at least **[**31 days**]** before the effective date of the change; and
2. on any date that the terms of the Policy are amended. We will give the Policyholder written notice of the change in Premium rates at least **[**31 days**]** before the effective date of the change**[**.**][**; and
3. on any date that the number of Covered Persons changes **[**by 10% or more**]**. We will give the Policyholder written notice of the change in premium rates.**]**

TERMINATION OF COVERAGE

Termination of Individual Coverage.
Coverage for a Covered Person shall automatically end on the earliest of the dates specified below:

1. the date the Policy is terminated;
2. the last day of the month in which you no longer meet eligibility requirements, unless an alternative date is otherwise stated in the Policy. You must notify us in writing within **[**30-60**]** days of a change, or termination of court or administrative ordered coverage;
3. the end of the period for which premium was last remitted for a Covered Person by the Policyholder if the Policyholder fails to remit premium when due;
4. the end of the period for which the last premium contribution is made, if premium contributions by you are required;
5. the date the Policyholder terminates the coverage for the Eligible Person's unit or class;
6. the last day of the month in which you are disabled, laid-off or on leave of absence.
7. the date you replace this coverage with another health benefit plan;
8. the date specified by us in written notice to the Covered Person that all coverage under the Policy will end because the person misused his or her identification card, including but not limited to permitting a person not authorized by us to use the Identification Card to obtain covered services.

In addition, coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder.

Dependent Coverage, if applicable, will cease on the earliest of the following dates:

1. the date you are no longer in a Eligible Class for Dependent coverage; or
2. the date you or the Policyholder cease premium payments for Dependent coverage; or
3. the date we cancel all Dependent coverage under the Policy; or
4. the date your coverage ceases.

In addition, Dependent’s coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked by you falls below the minimum required hours.

COBRA Coverage
A Covered Person whose coverage under the Policy would otherwise end may be entitled to elect continuation coverage under federal law or state law.

1. General Requirements:

   Continuation Coverage under COBRA applies only to employers which are subject to the provisions of COBRA. The Covered Person should contact the Policyholder's plan administrator to determine if the Covered Person is eligible to continue coverage under COBRA. We are not obligated to provide continuation Coverage to a Covered Person if the Policyholder or its designated plan administrator fails to perform its duties under federal law. These duties include but are not limited to:
   (a) notifying the Covered Person in a timely manner of the right to elect continuation coverage; and
   (b) notifying us in a timely manner of the Covered Person's election of continuation coverage.

   We are not the Policyholder's designated plan administrator and do not assume any duties of a plan administrator pursuant to federal law.

If the Covered Person chooses continuation coverage under a prior plan which was replaced by the Policy, the Covered Person's continued coverage shall terminate as scheduled under the prior plan or in accordance with the terminating events stated in item 4 below, whichever is earlier;

2. Qualifying events for COBRA Continuation Coverage:

   If the Covered Person's coverage terminates due to one of the following qualifying events, the Covered Person is entitled to continue coverage. The Covered Person may elect the same coverage that the Covered Person had at the time of the qualifying event. Qualifying events are:
   (a) Termination of the Eligible Person from employment with the Policyholder or reduction of hours, for any reason other than gross misconduct; or
   (b) Death of the Eligible Person; or
   (c) Divorce or legal separation from the Eligible Person; or
   (d) A Dependent child's loss of eligibility; or
   (e) Entitlement of the Eligible Person to Medicare benefits; or
   (f) For a retired Eligible Person and his or her Dependents, the filing of Chapter 11 bankruptcy by the Policyholder;

3. COBRA Notification Requirements and Election Period:

   The Covered Person must notify the Policyholder's designated plan administrator within 60 days of his or her divorce, legal separation or loss of eligibility as a Dependent.

   Continuation must be elected by the later of:
   (a) 60 days after the Covered Person's qualifying event occurs; or
   (b) 60 days after the Covered Person receives notice of the continuation right from the Policyholder's designated plan administrator.

   The Covered Person must pay the initial premium due to the Policyholder's designated plan administrator within 45 days after electing continuation. The Covered Person's monthly premium under COBRA may exceed the Group rate;

4. Terminating Events for COBRA Continuation Coverage:

   COBRA continuation under the Policy will end on the earliest of the following dates:
   (a) 18 months from the date continuation began, if the Covered Person's coverage ended because employment was terminated or hours were reduced. If a Covered Person is disabled at any time during the first 60 days of COBRA coverage, beginning on the day after termination of employment or reduction in hours, continuation coverage may be extended to a maximum of 29 months. Tthe Covered Person must give notice of the Covered Person's disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend coverage beyond 18 months. If the Covered Person provides such notice, the Covered Person's coverage may be extended up to a maximum of 29 months from the date of such qualifying event or until the first month that begins more than 30 days after the date of any final decision that the Covered Person is no longer disabled. If the disabled Covered Person has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29 month disability extension. A Covered Person must provide notice of any final determination that he or she is no longer disabled within 30 days of such determination;
   (b) 36 months from the date continuation began for a Dependent whose coverage ended because of the death of the Eligible Person, divorce or legal separation from the Eligible Person, loss of

eligibility by a Dependent child or entitlement of the Eligible Person to Medicare benefits, in accordance with qualifying events 2b through 2e above;

(c) The date coverage terminates under the Policy for failure to make timely payment of the premium;

(d) The date coverage is obtained under any other group health plan. If such coverage has a limitation or exclusion with respect to a Covered Person's pre-existing condition, continuation will end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health care except health care which is subject to the pre-existing condition limitation or exclusion. If the other group health plan's pre-existing condition limitations or exclusions cannot be applied because of the restrictions under the Health Insurance Portability and Accountability Act of 1996, then COBRA continuation will end on the date the Covered Person became covered under the other group health plan;

(e) The date the Covered Person becomes entitled to Medicare, except that this will not apply if the coverage was terminated because the Policyholder filed for bankruptcy, in accordance with qualifying event 2f of Section (2) above;

(f) The date the Policy terminates;

(g) The date coverage would otherwise terminate under the Policy.

If the Covered Person’s coverage ended because employment was terminated or hours reduced as described in item 2a above, and during the 18 month continuation period a second qualifying event occurs, coverage may be extended up to a maximum of 36 months. The 36 month period starts from the date coverage ended due to the first qualifying event. If the Covered Person is entitled to continuation because the Policyholder filed for bankruptcy, as described in item 2f above and the retired Eligible Person dies during the continuation period, the Dependents are entitled to continue coverage for 36 months from the date of death. Terminating events 4b through 4g shall apply during any extended continuation period.

A Dependent whose continuation coverage terminates because the Eligible Person becomes entitled to Medicare should contact the Policyholder's designated plan administrator for information regarding an extension of continuation Coverage for an additional period of time.

[Continuation coverage under COBRA is not available to Domestic Partners, if Domestic Partner coverage is available to the Covered Person.**]**

GENERAL PROVISIONS

Conformity with State Statutes. If any part of the Policy does not conform to a statute in the state in which it is issued or delivered, it is amended to conform with the minimum statutes of that state.

[ERISA. If the Policy is being purchased to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. Section 1001 et seq., We are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.**]**

Legal Actions. No action at law or in equity may begin prior to 60 days after we receive a valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

Workers' Compensation Not Affected. The Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

Important Notice. If you or any Covered Person has any questions or concerns about coverage under the Policy or if you or any Covered Person would like to make any comments or complaints, please call **[**1-800-XXX-XXXX**]**.

APPEAL OF PRESCRIPTION DRUG PROGRAM CLAIMS

The appeals process begins when you or the your representative submits a request for benefit coverage in writing. The Pharmacy Benefit Manager reviews this request and either approves or denies coverage in writing based on the plan's parameters (i.e., initial benefit determination). Written notification of pre-service requests is provided within 15 days. Written notification of post-service requests is provided within 30 days.

Level One Appeals Process

If a request results in a denial or reduction of coverage, you may appeal the decision in writing within 180 days after receiving notice of the initial claim decision. To start a level one appeal, You or Your authorized representative (such as your doctor) must provide, in writing, your name, member ID, phone number, the prescription drug for which a claim has been denied, and any additional information that may be related to your appeal.

Additional information for appeals should be mailed to:
[Appeals Administrator
Address
City, State Zip**]**

The additional information will be reviewed and evaluated by a dedicated appeals unit at the Pharmacy Benefit Manager to determine if the drug use meets coverage conditions specified or intended by the plan. If approval is granted, benefits are authorized for the proposed drug therapy. If a claim is denied, in whole or in part, the notice will refer to the specific plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your denied claim.

Level Two Appeals Process

If you are not satisfied with the initial appeal decision, you may request in writing, within 90 days after receiving notice of the appeal decision, a level two appeal. The level two appeals committee for administrative appeals consists of three professionals: a Pharmacist supervisor, a Pharmacist, and either an additional Pharmacist or a managed care representative or quality assurance specialist. No level two appeals committee member, nor his or her subordinates, will have been involved in either the original coverage decision or the level one appeal.

Expedited Appeals

You may request that the appeal process be expedited if the periods under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your doctor, would cause you severe pain which cannot be managed without the requested services. When an appeal is expedited, the Pharmacy Benefit Manager will respond orally with a decision within 72 hours, followed up in writing.

[STATEMENT OF EMPLOYEE RIGHTS UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the employee group prescription drug plan provided by the Plan Sponsor, (the "Plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. The Plan Administrator for your plan may be your benefits committee or benefits administrator, and is specified in the Plan's Summary Plan Description. Your Plan Administrator is not Nationwide Life Insurance Company. Your Certificate of Coverage is not the Plan's Summary Plan Description. ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other locations (worksites and union halls), all documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U. S. Department of Labor, such as annual reports and plan descriptions.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The Companies are not fiduciaries of the Plan.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court against the Plan. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court, if you have exhausted the remedies provided for review of Adverse Benefit Determinations. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.**]**

Stonebridge Life Insurance Company
Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**

Prescription Drug Plan
EMPLOYER APPLICATION

Requested Effective Date: / /

Premium Deposit: $_____
Approximately 1 month's premium, payable to "Stonebridge Life Insurance Company"

Group Representative:

Plan Selected: **[**• Value Generic

Generic:	Participating Retail Pharmacy:	Tier 1 Company ____; ____day supply
Generic:	Participating Retail Pharmacy:	Tier 1 Company ____; ____day supply
Generic:	Mail Order:	Tier 1 Company ____; ____day supply
Generic:	Mail Order:	Tier 1 Company ____; ____day supply
Brand-Name:		____% of discounted amount;
Specialty:		____% of discounted amount**]**

Premium: **[**• Prescription Drug Coverage – Employee Only: $_____
• Prescription Drug Coverage – Employee + Child: $_____
• Prescription Drug Coverage – Employee + Spouse: $_____
• Prescription Drug Coverage – Employee + Family: $_____**]**

Application is hereby made for the Benefits set forth herein.
The information given below shall be the basis of the agreement with the Plan Sponsor.

Administrative Information

Legal Company Name

Location Address | **City** | **State** | **Zip** | **County**

Mailing Address (if different than above) | **City** | **State** | **Zip**

Phone ( ) -

Administrative Contact

Fax ( ) -

Title

Email Address | **Business Start Date** | **Employer's Tax Identification Number**

List names and addresses of all affiliates, branches or subsidiaries on a separate sheet of paper and submit with this application.

Billing Arrangements: Are there multiple units/locations to be billed separately?

• No • Yes – number of units _____ • Bill to Individual Units • Bill to Plan Sponsor

Describe the Nature of Business | **SIC Code**

Number of Employees working [20] or more hours per week year-round _____
Number of Employees working fewer than [20] hours per week year-round _____
Number of Employees working other hours, seasonal, etc. _____ **(please describe)**
Please submit copy of most current Employer's Report of Wages and Employer's Contribution Report ("OBES" Report).
For any company owners not shown on the Employer's Report of Wages, submit other documentation showing earnings from this business, such as tax Form 1099 or Schedule (C, K-1, SE, etc.).

Are any of the employees noted above part of an Employee Leasing Firm or a Professional Employee Organization? • No • Yes

List the Names and Dates of Birth of all former Employees/Dependents on Continuation of Coverage or COBRA:
Include completed COBRA form for each

_____ _____
_____ _____
_____ _____
_____ _____

Will this policy be replacing an existing group Health Plan?	• No • Yes – Current Carrier:
Employer Contribution:	_____% of Premium Amount
Participation Requirements:	_____% of Employees
Eligible Classes Requested: **[**• All employees • All Employees • All regular full-time Employees • All Employees, except _____ • Dependent of Employees • Other _____**]**	
Waiting Period: **[**• Waiting Period (current Employees): • Effective Date • 2 Months • Other _____ • 1 Month • 3 Months • Waiting Period (new Employees): • 1 Month • 2 Months • Other _____ • 3 Months • Date Employed New Employees are covered on the first day of the month following the Waiting Period**]**	
Open Enrollment Period: **[**• Dates_____ • Not Applicable	

General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. Benefit Coverage shall not become effective unless this application is accepted and approved by the Stonebridge Life Insurance Company.
2. All benefits will be issued on a non-occupational basis unless otherwise indicated.
3. The prospective Plan Sponsor (or the administrator) will furnish and maintain records required to administer the benefit plan, will report changes prior to the effective date of a change in the group, and will make all premium payments according to the terms of the contract.
4. The employer will collect employee contributions through payroll deductions.
5. The prospective Plan Sponsor has received and reviewed a Stonebridge Life Insurance Company proposal, and understands the material facts contained in the proposal.
6. Coverage will be deferred until the annual enrollment period for any eligible employee considered a Late Enrollee. Special Enrollees are exempt from this deferral.

Do not cancel your current insurance plan until you have received written confirmation of acceptance by Stonebridge Life Insurance Company.

Stonebridge Life Insurance Company relies upon the accuracy of information included on the application and enrollment forms in determining the appropriate Premium rate for this Applicant. We reserve the right to retroactively adjust the Premium rate at any time in the event we determine that inaccurate information was provided to us upon which we relied in determining the premium rate. If the readjusted Premium is not paid, the Policy will be terminated. Failure to meet participation requirements will also result in an increase to the proposed rates or may result in termination with 45 days notice.

[Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**]**

Dated At:
Dated On:

By: _____ _____ _____
Signature of Employer *Printed name of Employer* *Job Title*

Employer's signature witnessed by *(must be 18 or older)*:

_____ _____
Signature of Witness *Printed name of Witness*

SLRX2010GA

Stonebridge Life Insurance Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201**]**

Prescription Drug Plan

EMPLOYEE ENROLLMENT FORM

Employee Last Name	Suffix (e.g., Sr., Jr.)	First Name	M/I	E-mail Address	Home Phone
					( ) -

Residence Address	City	County	ST	Zip Code	Business Phone
					( ) -

Mailing Address if different than above:

Social Security Number	Date of Birth	Gender
- -	_____-_____-_____	• M • F

Employer Name	Job Title	Hours Worked Per Week _____	Earnings Reported on • W2 • Other (Explain)_____

- Active Employee – List Full-Time Hire Date _____-_____-_____
- COBRA Coverage – List Qualifying Event Date _____-_____-_____ & Description

Section II – Election or Refusal of Coverage

Please check a box for each coverage.

Elect: **[**• Prescription Drug Coverage – Employee Only • Prescription Drug Coverage – Employee + Child
• Prescription Drug Coverage – Employee + Spouse • Prescription Drug Coverage – Employee + Family**]**

Refuse: • Prescription Drug Coverage

If not electing coverage, is the reason you are refusing because you are currently covered by an employer-sponsored health plan?
• No • Yes If yes, please list the following: Employer Name Carrier Name Policy #

IF YOU ARE REFUSING COVERAGE, PLEASE READ THE IMPORTANT NOTICES IN SECTION IV, SIGN HERE AND STOP.
IF YOU ARE ELECTING COVERAGE, PLEASE COMPLETE ALL REMAINING SECTIONS.

_____ _____ _____-_____-_____
Employee Name (Print) Employee Signature Date

Section III – Enrollment Information

If your employer is offering dependent coverage, list all your dependents to be covered. (Use separate sheet if necessary.)

Relation	Name: Last, Suffix (e.g. Sr., Jr.) First, MI) 1	Social Security Number	Date of Birth2	Gender
Spouse		- -	- -	• M • F
Child		- -	- -	• M • F
Child		- -	- -	• M • F
Child		- -	- -	• M • F

1) For each spouse or child whose last name is different than the employee's last name, clearly indicate reason (e.g. employee or spouse kept maiden name; child from a previous marriage or relationship; other)_____
2) For each child over the age of 18 and a full-time student, submit documentation from the accredited school showing full-time status, such as current course schedule or grade report.

Section IV – Please Read the Following Important Notices

Late Enrollees If you are waiving/declining health coverage for yourself and/or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself and/or your dependents if the other health coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents for health coverage, if you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you waive/decline coverage for yourself and/or your dependents for any other reason, you may be considered a late enrollee and will only be permitted to enroll during the group's annual enrollment period, subject to the pre-existing conditions limitation.

Confirmation I agree that the information set forth on this enrollment form is correctly recorded, complete and true to the best of my knowledge and belief, and that it forms the basis of my insurance. I further agree that the Certificate together with this Enrollment Form, the Policy, and Policyholder's Application, and any amendments or riders will completely describe the benefits and conditions of the insurance agreement. Stonebridge Life Insurance Company (hereafter referred to as "Company") will rely and act upon the answers

and information I provide on this Enrollment Form. The Company reserves the right to retroactively adjust the premium rate for the group at any time in the event of a material misrepresentation of information has occurred. My insurance coverage will not become effective until this Enrollment Form is received and approved by the Company, and in no event prior to the effective date of the Policy issued to my employer.
Your coverage is subject to an agreement with Participating Retail Pharmacies. It is important that you verify that your pharmacy is a participating pharmacy each time you make a purchase.

Section V – Please [Read,]Sign and Date (in ink) Below

[Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**]**

_____	_____	_____-_____-_____
Name of Employee (Print)	Employee Signature (In ink)	Date